SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION

NATIONAL ADVISORY COUNCIL

Tuesday,
September 9, 2003

Chevy Chase Ballroom
Embassy Suites Hotel
at the Chevy Chase Pavilion
4300 Military Road, N.W.
Washington, D.C.

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P R O C E E D I N G S (9:10 a.m.)

MR. CURIE: Good morning, everyone. I'd like to welcome all of you to this meeting of the SAMHSA National Advisory Council and actually call the meeting to order. It's good to see all of you again. In particular, there's a couple of folks I want to welcome this morning that are new to us this morning.

First I'd like to welcome Joel Slack. This is his first meeting. You may recall he was on deck for the last meeting but he decided, since his wife was having a baby, that was more of a priority than the National Council, and I think we agree.

Again, we want to extend our congratulations to you, Joel.

Joel does have pictures.

(Laughter.)

MR. CURIE: But I'm just so pleased Joel accepted the invitation to be part of this advisory council. I've known Joel for many years, and he's just one of the most capable spokespersons I know when it comes to helping people understand mental illness.

So thank you, Joel, for coming aboard.

I also want to welcome Dean Messelheiser. Welcome. Dean comes to us to represent the Department of

Defense, and we appreciate you being here today and welcome your participation with the National Council. Anything you'd like to share?

COL. MESSELHEISER: No, thank you.

MR. CURIE: Okay. Thank you.

Also, I'm sorry to report that Thomas Lewis, who was with us last time, could not be with us because of a serious personal illness. Again, we'll be staying in touch with Thomas and keeping him in our thoughts and our prayers.

I want to start today by saying that I think the stars are somewhat aligning for SAMHSA in very positive ways. You represent a new Advisory Council. We have an unprecedented support from Secretary Tommy Thompson and our President, and we have a new executive leadership team at SAMHSA.

Since we last met, Kathryn Power has joined SAMHSA as the new Director of the Center for Mental Health Services. Kathryn came to us from Rhode Island. She was director of mental health and drug and alcohol for the State of Rhode Island. Those who have been in the field for many years know that Kathryn has been a strong leader in the field, understands public policy as well as management, and is a tremendous addition, already has hit the ground running. I think Ted Searle, who is representing CMHS today, is the

Deputy Director, would testify to the fact that she has clearly hit the ground running, and I want to welcome you here today, Ted, for being here on her behalf.

Also, James Stone has joined my immediate office as Deputy Administrator. Jim was commissioner of mental health in New York, again understands the issues inside-out. In fact, he was appointed commissioner of mental health in New York and started the exact same day I started in Pennsylvania. So Jim and I have been colleagues for many years. But Jim coming aboard as chief operating officer, again he's in the fray, sleeves rolled up and on top of the agenda.

Kathryn, the reason she could not be with us, I think I mentioned, is because of reserve duty in the military, but she will be here for our next meeting.

In addition to Ted, who is representing CMHS, I'd also like to welcome Beverly Watts Davis, who you met last time, still a relatively new person for SAMHSA, the Director for Substance Abuse Prevention. I believe Westley is not here yet. He'll be joining us later. Dr. Westley Clark, our Director for the Center for Substance Abuse Treatment.

Now I would like to introduce my good friend and longtime former colleague who also is a state, or is a state -- I was a state director, state director of mental health in Wyoming. My co-chair and esteemed colleague, Pablo Hernandez.

Pablo?

DR. HERNANDEZ: Thank you.

Welcome, each and every one of you. I have a couple of announcements to make that have not been mentioned before. Two members of our Council will not be able to be here today. Jane Maxwell has conflicting scheduling. She may come in and out. Let's see what happens. But Dr. Mary Burns will not be able to be with us at all. I just wanted to let you know that.

But I would like to take this opportunity for Joel. The last time, we got to know each other a little bit. Can we get to know you a little bit? Would you mind?

MR. SLACK: Well, I suppose. You caught me off guard.

My name is Joel Slack and I currently live in Montgomery, Alabama. Up until about six months ago, five months ago, I sort of needed to represent myself as a consumer advocate. Of course, now I represent myself as a father, a very proud father of Anna Isabella.

I was introduced into the mental health field as a patient. I spent two and a half years in psychiatric hospitals after attending a university on a basketball scholarship, and spent four years depending on community mental health services.

I was able to go back to college and earn a degree in international economics and business psychology. I had all the abnormal psychology I wanted up to that point.

(Laughter.)

MR. SLACK: So I studied business psychology. A few years later, after working in the corporate world, I decided that I felt like I had abandoned those who I had experienced mental illness with, and so I became an advocate.

I think my first experience as an advocate was starting the Office of Consumer Relations, which is having state mental health agencies employ consumers in senior management positions, giving them a more powerful platform and opportunity to guide the system. I've been involved in the CMHS National Advisory Council. Currently I do a lot of international work, in particular with developing countries. I guess what I do the most is about six or seven years ago I started presenting a seminar called the Respect Seminar. I think this probably symbolizes the thirst and the hunger out in the field for a greater understanding for mental illness and how to treat people with mental illness.

But in the last seven years, I've given that seminar to about 80,000 people all over the world. It's my attempt, as Bill Anthony from Boston University says, to make sense out of experiences that don't make any sense. So

currently I do a lot of work in different states, training, consultation on how to involve consumers, treat them more respectfully, and I'm currently the director of Respect International, which is an organization I founded.

Thank you.

DR. HERNANDEZ: Thank you, Mr. Slack.

I think we did send to all the members an invitation per our request to look at what are the areas of activities that you would like to consider as part of your ambassadorship, and we appreciate very much your responses. We are going to be working on that later on. So in case you have other desires to be ambassador of and areas of interest that you did not put down on the first round, be thinking about it so we can add it on to your charge and to the areas that you would like to bring forth. So please, because that will be an area that we will be discussing later on.

Mr. Chair, I will turn the podium to you, sir.

MR. CURIE: Thank you, Pablo.

Before I share the Administrator's Report, I would like to take a moment to also welcome all those in the audience this morning. I see many of the significant strong leaders in the drug and alcohol and mental health field and arena here today and appreciate your ongoing interest in support of SAMHSA and its three centers and fulfilling our

mission. I look forward to many of you sharing remarks and participating in the meeting today.

I also would like to ask that we do a quick round around the table. We've already heard from Joel as the newest member of the table, but beginning with Bert, have the members of the Advisory Council just introduce themselves for the record and anything you want to say about yourself.

Bert?

DR. PEPPER: I just would express my appreciation for the opportunity to be here today, Charlie. Bert Pepper from New York.

MS. RACICOT: I'm Theresa Racicot of Montana, and now of Virginia, and I'm very honored to be here. Thanks to Mr. Curie. I just hope to lend whatever I can. Thank you.

MS. HUFF: Hi. I'm Barbara Huff, and I'm the director of the Federation of Families for Children's Mental Health in Alexandria, Virginia. I would also like to say thank you to Charlie for the pleasure of serving on his Council. I also just want to say for the general population of people that I represent families who have children in adolescence with mental health problems or challenges. So that's me. I'm from Kansas originally and have lived here about 10 years, and I'm excited to have this experience. Thank you.

MR. CURIE: Thank you.

Kathleen?

MS. SULLIVAN: My name is Kathleen Sullivan, and I'm an Emmy Award-winning journalist. I started CNN, so that's the first time I was known nationally, and I publicly self-destructed. My father committed suicide. Two months later I was fired by CBS, and little did I know that mental illness actually destroyed my family for generations.

I was diagnosed with bipolar illness maybe three years ago, maybe one and a half years ago, and little did I know, when I decided to treat my illness, that I would be then considered a pariah, but as long as I ignored it I would be okay. So now I don't know if I would be an advocate, but Charlie I guess has made me one. I've been bicoastal, but now I'm publicly bipolar, and I am very much an advocate and very proud to be here. To all of you who are here, I can't thank you for the roles that each one of you play. If I can ever be of public service to any of you in your organizations, please know that I am here at your behest.

MS. DIETER: I'm Gwynneth Dieter. I'm from Boulder, Colorado. I'm a mental health advocate, I would say. I have a family member who has a dual diagnosis, and I bring my experience from the consumer side and my passion to extend education to the public and to improve access to care. It is

a real privilege for me to be here today. Thank you.

DR. GALLANT: Good morning. Good morning, Charlie.

My name is Lewis Gallant. It's good to be on the Council. I'm the executive director of the National Association of State Alcohol and Drug Abuse Directors. Our organization represents the interests of the AOD authorities in the 50 states and territories, and we try to ensure that we are able to provide an array of services that meet the needs in prevention and treatment for the citizens of those states.

We are very happy that we have a good, solid relationship with SAMHSA, and in particular with our new -- well, not new Administrator anymore.

MR. CURIE: I'm pretty old.

DR. GALLANT: Yes, you've been around for a while. But I think, as I mentioned last time, this is one of the few times that -- I've been in the field for over 35 years, and I've been in the state/federal arena now for probably a little over 12, and in those years this is the first time that I've been at a federal agency that had a leader with vision. I was telling someone a couple of weeks ago, it's nice to know that we have identified a few things that we want to take a look at, try to resolve, and get support and resources for, and I think that's the result of

Charlie's vision as the Administrator of SAMHSA.

I think that matrix really demonstrates how you can really refine your efforts down to a few things you really want to tackle and then go after them. I think you will probably hear over the next couple of days how we have made progress on all those innovations.

Last, I'd like to thank President Bush in particular for making substance abuse a centerpiece of his administration. I haven't seen this happen before in my professional lifetime. I think when I entered the field, President Nixon was the first one who really put money on the table to expand and recognize that substance abuse is a national priority and is a national issue and is a federal issue. He did deal with that. Now we have President Bush, who has put $1.6 billion on the table, and we clearly have not had that kind of infusion of new resources in a mighty long time.

So with that leadership, I ask that we acknowledge that. It's important that we acknowledge that, because without the support from us in the field, many of the things that he wants to do cannot be achieved. So I think as a field we must take this as an opportune moment, because we may not have this again, and do what we need to do to support the President's agenda as best we can and to help get the

resources our field requires.

MS. HOLDER: Good morning. I'm very happy to be here. I'm Diane Holder, and I'm the president of Western Psychiatric Institute and Clinic and the vice president for behavioral health services for the University of Pittsburgh Medical Center in Pittsburgh, Pennsylvania. I am delighted to be able to be here as a Council member.

I've spent I think about the last 10 years of my life trying to really figure out, along with many others, how it is that you take what it is we know seems to help people and try to get it into everyday practice. I think that if we take this opportunity, and I think with SAMHSA taking the lead to implement the Presidential Commission report, we are at an unprecedented time in history. If we can actually move this agenda and be helpful in any way to do that, it will mean recovery for so many people that otherwise won't have an opportunity to live a meaningful life.

So I think that it's an honor to be here, it's a privilege, and I think with the new leadership at SAMHSA it's going to make a difference.

MR. CURIE: Thank you, Diane.

An individual who you're going to hear from a little later who has arrived and I mentioned earlier, James Stone, the new Deputy Administrator of SAMHSA. I think I was

one of the happiest people in the world when Jim walked through the door.

MR. STONE: The second happiest.

(Laughter.)

MR. CURIE: So welcome, Jim.

MR. STONE: Thanks.

MR. CURIE: And Daryl Kade, who is our Executive Director, and also our very able Director of Policy for SAMHSA and invaluable member of the executive leadership team. You'll be hearing from Daryl as she facilitates the meeting at points throughout the process over the next two days.

Never before has SAMHSA been in the middle of so many major initiatives, ranging from developing and implementing the President's Access to Recovery program, which Lewis was mentioning as an example of the commitment the President has to addressing substance abuse and assuring that those who are trapped in addiction have the opportunity for treatment, recognizing that treatment does work and that recovery is real, to creating an action agenda around the recommendations included in the final report of the President's New Freedom Commission on Mental Health. We've scheduled time in the agenda to discuss in depth each of these initiatives with you during this meeting.

However, to set the stage for these discussions,

I want to emphasize and at the risk of being repetitious remind you that at SAMHSA, we structure our work around a vision of a life in the community for everyone. That life includes a job, an education, a home, and is rich with meaningful personal relationships.

As many of you know, to help turn this vision into a reality, we've defined our mission as building resilience and facilitating recovery. Working together will ensure that anyone of any age who has or may one day develop a mental or substance abuse disorder has the opportunity for that rewarding life in the community.

Hearing many of you talk around this table, and Diane just finishing her remarks about a meaningful life, framing recovery I think is critical. We've defined a rewarding life not by what it might mean to the people who work at SAMHSA or professionals who work in the field, or only in terms of alleviation of symptoms, but we talk about it in terms of how people talk about it who are mentally ill, people who are addicted, people who are in recovery.

People, in working to achieve recovery, again they don't say that they need a primary care physician or a psychiatrist or a case worker -- thank you, Kathleen -- to follow them around. They don't say they need an addictions counselor, and I never have figured out why they don't say

they need a social worker, but I accept it. But they do say they need a job, they need meaningful day to day activity where they're pursuing an education. They need a home, safety, a place to live, a place where they feel safe, a place that reflects their identity as to who they are.

Many of you have heard many times my talking about they need a date on the weekends, and that's a quote from many folks. But again, meaningful relationships where they're connected to family and friends. The reason I think that's critical to understand is not only does it help us begin to align our resources around particular end results that we're looking for, but I think it's a greater message to the public at large that people with addictive disorders, people with mental illness, children and youth with serious emotional disturbances, or children and youth who are at risk are people first, and that really the end goal they're looking for in their lives are really the end goals we all look for. They want a life, a real life with all its rewards.

To help guide our work and to help keep our vision and mission real, I'm pleased that Lewis mentioned the matrix. I did hear you do have it now framed in your home, Lewis.

(Laughter.)

DR. GALLANT: And in my office.

MS. SULLIVAN: I have one as a placemat.

(Laughter.)

MR. CURIE: You have a placemat? Good, good.

We created the matrix of agency priorities and principles to guide our program development, as well as our resource allocation. Again, the matrix does demonstrate SAMHSA's direction. It's a visual depiction of our priorities and principles.

I want to stress again that the matrix is a flexible tool. I believe Charles Ray was the first one to use the term. The new refined matrix that is going to be coming out will be known as the "Matrix Reloaded."

(Laughter.)

MR. CURIE: You'll be seeing that in a couple of weeks. In fact, any day now we'll be releasing that. It will include some changes. Instead of the New Freedom Initiative and the Commission being mentioned, that particular part of that axis will be changed to Mental Health System Transformation, transforming the mental health system. We'll be talking more about that in place of the New Freedom Initiative.

We'll also include the strategic prevention framework as a major focus and activity around our substance abuse prevention area and arena, as well as representing the

nexus with mental health in terms of strengthening a prevention and early intervention agenda there. Also, we're going to be again focused on substance abuse treatment capacity. That's not going to be changing because access to recovery is what's going to be focused on there.

In terms of our cross-cutting principles, I think you'll be seeing a few changes there that we're going to be focused on managing for outcomes, and you're going to be seeing just a few modifications along those lines. One of the major modifications you'll be seeing is, now that we have a new executive leadership team and positions filled more permanently than we did before, some reassignments as to who the executive leadership team leads will be in those particular areas as well.

Again, later today we'll discuss the New Freedom Commission on Mental Health final report and plans for developing that action agenda. That final report called for profound change and transformation of the current system. In fact, it calls for new service delivery patterns and incentives to ensure that every American with or at risk for a mental illness has easy access to the most current treatments and best support services, with special emphasis on providing access to treatment and support services for people in rural areas and people who are minorities.

In particular, recommendations were made to improve access to quality care, to use health care technology and telehealth to improve access and coordination of mental health care, and to develop and implement integrated electronic health records and a personal health information system. That's critical not only from a standpoint of quality management, not only from a standpoint of access to care and access to the best information, not only to assure access to remote areas in this country, but it's also critical because it represents one of those things that's part of overall health care transformation and the health care agenda that the Secretary has overall.

You'll see reflected in this report how the Mental Health Commission report is very much aligned with and part of health care transformation in this country. In fact, in many ways we have the opportunity to lead in certain areas because of, I think, how clearly the report depicted many of the issues.

In addition, the report calls for the implementation of a national strategy for suicide prevention, as well as a national campaign for reducing the stigma of seeking care. SAMHSA has been charged with conducting a thorough review and assessment of the report, with the goal of implementing appropriate steps to strengthen our mental health

system.

We're looking at not only an action agenda for the federal agencies -- and again, what will be involved is a cross-cutting agenda developed with the fellow federal agencies who are represented as ex-officio members of the Commission, and we already have a running start with relationships with those particular agencies. That includes Education, it includes HUD, Housing, it includes the Veterans Administration. It includes, of course, within HHS the National Institutes for Health, NIMH in particular. It also includes Labor, and we're also going to be engaging Criminal Justice, who was not represented on the Commission, but they're also going to be involved in that process.

All those agencies which are necessary to have at the table to facilitate recovery, and I cannot forget CMS. CMS, I have to say, participated fully in the Commission process. They're right there with us with the action agenda, and they're another example of why I think we're poised for a great opportunity that we haven't had before in terms of alignment of financial resources.

Our challenge, of course, is to build a mental health system that is both consumer and family driven and focused on recovery and resilience. We'll be looking in particular at the programs cited by the Commission as models

of mental health care transformation. In other words, we found pockets of excellence in this country. There's a lot of good work going on, and what we want to do is to be able to bring that good work that was identified by the Commission and bring it to scale nationally so that it's the day to day expectation of how people will receive services. Our aim will be to identify ways in which the best elements of those models can be brought to that scale nationwide.

Another new initiative in the matrix is building again substance abuse capacity through -- it's not new but it's going to continue -- developing substance abuse treatment capacity. SAMHSA has long been reaching out to states to provide treatment services for people who have substance abuse problems, the substance abuse prevention and treatment block grant and the Targeted Capacity Expansion grants. We're committed to continuing to support the substance abuse prevention and treatment block grant. It's the backbone of the state-run drug and alcohol system.

States is where the action is when it comes to substance abuse treatment and prevention. If it wasn't for state drug and alcohol authorities and the block grant and the match, we would really not have a public drug and alcohol treatment system in this country. I see Lewis nodding to that. So it's absolutely essential that we keep that

particular funding stream strong. It represents almost $4 billion if you consider the state match in terms of supporting treatment, and 20 percent of that $4 billion also goes toward prevention efforts in the states.

Our Targeted Capacity Expansion program, which totals right around $320 million right now, helps us address new and emerging substance abuse trends by focusing on local needs. The grants provide flexibility and agility to meet the treatment needs that emerge in the most relevant way.

So together, the block grant and TCE have made strides in expanding our capacity for substance abuse treatment. If you take a look at where the substance abuse treatment delivery system is today compared to 30 years ago, there's no comparison. It's professionalized, it's structured, there's better access than ever before. We still have a ways to go to keep moving the ball down the field, so to speak, to reach the goal; but again, we have found that treatment does work and that we do have a system that represents a level of effectiveness.

But we also have found that our capacities are not sufficient. Our latest National Household Survey, which we released last Friday, found in 2002 that 6.3 million of the 7.7 million people needing treatment for an illicit drug problem never got help. Of the 6.3 million, only 362,000

reported they felt they needed treatment for their drug problem. In fact, 88,000 -- and the range the last two years has been anywhere from 88,000 to 120,000 people -- knew they needed treatment, sought treatment, but could not find treatment.

Of course, we know, with denial being such a major factor in substance abuse and addiction and dependence, when someone is ready to find treatment, not to have access, we miss the opportunity. It's very easy for them to walk away very quickly if there is not access to that care.

President Bush emphasized this very point in his January 2003 State of the Union address when he said, "Too many Americans in search of treatment cannot get it." He reaffirmed his commitment to expand the nation's substance abuse treatment capacity by proposing Access to Recovery, a $600 million program to help an additional 300,000 Americans receive treatment over the next three years. Access to Recovery will increase treatment capacity by expanding access to treatment and the array of support services that are critical to recovery, like medical detox, inpatient/outpatient treatment, residential services, peer support, relapse prevention, case management and other services.

The first $200 million installment is included in the President's proposed FY '04 budget for SAMHSA, which is

currently before Congress, and it's expected to result in treatment availability for an additional 100,000 persons per year. This new initiative, coupled with what I described earlier, SAMHSA's ongoing efforts with the block grant and the TCE, can create profound change in the delivery and accountability of substance abuse treatment services. Ultimately, we hope to create profound change in the lives of millions of Americans addicted to drugs and alcohol. However, we can't do any of this if we're working alone in our administrative, programmatic, or funding silos. We must change the way we do business or we're not going to serve the people who need us most.

As Secretary Thompson often reminds us, our individual actions as separate agencies within the Department of Health and Human Services pale in comparison to our combined efforts. Secretary Thompson articulated a vision of what he calls "one HHS" and outlined several steps to promote interagency cooperation. Again, already agencies have done that. Later today you'll be hearing more directly from Betty Duke, the Administrator of HRSA. SAMHSA and HRSA have begun working together. We've begun partnering, first on a federal level, and soon this message will echo a new partnership among states and among individual communities.

Ultimately, these partnerships will be expected

and no longer suggested. It just makes good sense. As SAMHSA and HRSA continue to work together to build and improve partnerships, the integration and coordination of mental health services, substance abuse treatment services, and primary health care services throughout the nation will improve as well.

So we at SAMHSA and HRSA, the Institutes, and the entire Department of Health and Human Services are determined to bring the full force of our many service delivery systems together.

That gives you an idea of some of the major things where we have a focus right now, and we'll be talking more in depth again about the substance abuse treatment initiative. We also are going to be sharing an update on how we'll be moving with the data vision, the strategy around gathering data and doing it in a way that's going to make sense around the outcomes we're expecting, and also efficiently so that we're not just putting more and more demands on states and providers for data without it all being connected and trying to streamline those efforts and do it in a strategic way.

You're going to be hearing about Access to Recovery more in depth, and again Gail and I a little later this morning will be sharing with you an overview of the

Mental Health Commission report.

It's now my privilege to introduce you to the new Deputy Administrator, Jim Stone. I'd like to ask Jim if he would please give some remarks at this point, remarks, reflections, insights.

MR. STONE: I'd be delighted to do that.

MR. CURIE: Jim.

MR. STONE: Thank you.

Well, Charlie, when he introduced me a minute ago, said that he was the happiest man around when I came on board, and I corrected him to say that he was the second happiest man. I was the happiest man. I have just come, as I think you know, from eight years as being commissioner of mental health for the State of New York, which was an exciting and very rewarding job, but I think, frankly, that's long enough and I was ready to do something else. I saw this as a marvelous opportunity.

Charlie's leadership, which has been extolled already by a number of you, has impressed me the last couple of years, and I think he's turned SAMHSA into an organization about which people were only vaguely aware. I'd like to say that when I became commissioner eight years ago, I got a call from SAMHSA, and I didn't know what it was. I think that's kind of shocking. True, it was only a couple of years old at

the time, but in fact I had been in the field for a long, long time, and the fact that I wasn't even aware of it I think is kind of shocking.

I think just in the last couple of years we've seen the profile of SAMHSA really escalate, and I think that is a tribute to Charlie's leadership and vision. More and more I'm becoming aware of the credibility that he's bringing to the job. I pointed out to him that I had to present a proposal at the HHS last week, and I went in there thinking that I would have to be a real salesman. In fact, I did not have to be a real salesman. Charlie had not sold that particular proposal before, but the fact of his credibility made my proposal, frankly, an easy sell. I joked with him that I could have sold almost anything and they would have gone along with it. I think that makes life easier for all of us in SAMHSA.

I'm happy to be here. I'm heartened to see all the familiar faces around, and I think I'm just looking forward to a good relationship with all of you. As I said, it's an opportunity to join a dynamic team. I'm still baffled by the traffic, as you might have noticed. I was a little tardy, but I guess I'll get used to it at some point, but I don't know when.

MR. CURIE: No, you won't.

(Laughter.)

MR. STONE: I won't? Oh, dear.

My recent role in New York focused on mental health, of course, but I did play a role in the substance abuse field. I worked with our leader of substance abuse services in New York, the commissioner of OSAAS, the Office for Substance Abuse and Alcohol Services, Gene Miller, who is known to some of you. We took a particular interest in co-occurring disorders.

Prior to that job, I was director of community services for Monroe County -- that's Rochester, New York -- which also included substance abuse and alcohol services. So I bring to this position I think a pretty good awareness of both fields, and I think that I'll be able to be a help to both systems in this role.

As I said, it's an exciting time to be here with Charlie's dynamic leadership and the credibility. Charlie has already outlined a lot of things I was going to point out. But the fact is that it is an exciting time to be here and that we're rolling out the President's New Freedom Commission report. You're right, in the sense that I think this President is paying attention to issues that are important to us here, and it is an opportunity that we shouldn't treat casually. We should jump right on it.

I think the matrix has gone a long way to establish SAMHSA's credibility across the nation. People get a much better sense of what we're interested in and what we're focusing on. The focus on recovery I think sends a message of hope, which is what this field needs more than anything else. It wasn't too many years ago that we never really heard that word in our lexicon, and now we are talking seriously about recovery.

Other issues that were interesting and exciting to me in New York are exciting to me here in Washington, and I'm glad that the focus is not only on recovery but science-to-service or evidence-based practices, and prevention and early intervention is important to me. I was glad to hear Charlie a few minutes ago talk about one of our matrix issues, and that's the criminal justice issue. I think that is one that we as a field need to pay more attention to, and I'm happy that that's a part of our responsibility here.

It's part of my responsibility I think to see if we can do a better job with what resources we have, and I intend to focus on that and work collaboratively with Charlie and the dynamic team that he's put together, and I think you should all watch our smoke.

Thank you, Charlie.

MR. CURIE: Thank you, Jim.

MR. STONE: To use an unfortunate term, by the way.

(Laughter.)

MR. STONE: A politically incorrect term.

MR. CURIE: You mean smoke in terms of speed.

(Laughter.)

MR. STONE: Yes. Acceleration.

MR. CURIE: Acceleration. Thank you. That's right.

MS. SULLIVAN: I live on the Agua Caliente Indian Tribal Reservation, where I lease land, so I was referring to smoke signals.

(Laughter.)

MR. STONE: Good. Thank you for bailing me out, all of you.

MR. CURIE: I'm talking about hitting the ground running. Again, one major advantage -- there are several advantages of Jim coming aboard, but he's known what it's like to be in charge of a large bureaucracy. New York State has not been accused of being a small bureaucracy ever. Jim was able to accomplish many things within a large bureaucracy. I can think of very few people who could come in with the credentials Jim did, stepping right in, and already I can just tell that the internal operations -- and Frank Sullivan has

been, I think, providing tremendous support in the transition process.

In terms of furthering the management agenda, it's seen some acceleration over the past few weeks already. So thank you, Jim, for being aboard.

I'd like to turn it over real quickly to -- Barbara, would you like to make a comment?

MS. HUFF: I just wanted to say thanks to Jim. From the family movement perspective, we haven't had a greater supporter, besides Charlie, of course, at the state level.

When I met Jim, I was doing a presentation for a conference at our family meeting, and I had no idea who he was, but he was sitting in the front row, and he had that pen in his hand, and he was kind of looking at me like, "Maybe we could do this." Then I found out later he was the commissioner. I might have handled things a little differently if I'd have known that, but what I want to say is that New York probably has the best family organization structure in the country, and that just doesn't come by the idea that we might want that. That takes a lot of support.

We have a very strong state organization. We have chapters all over the state that are affiliated with the mental health centers and other people doing business in counties, and I just want to say thank you for that because

it's an extraordinary model. I don't think we have the city exactly covered like we would want to as a family organization, but I just want to say thanks for your support in that. When I heard that you were coming here, I thought this is good, you know? We can do that. So thank you, Jim.

MR. STONE: Thank you, Barbara.

MR. CURIE: I think it speaks well of one's leadership and management when you can point to concrete examples of legacies that were left in New York, and I'm glad you mentioned co-occurring too. I do refer to Jim as the father of the Johari window for the quadrants that NASADAD and NASMHPD use as the conceptual framework on co-occurring disorders, because that originated from Jim and New York State.

MR. STONE: And Dr. Pepper.

MR. CURIE: And Dr. Pepper. And also, Jim's commitment to quality community-based care is undeniable in terms of the innovation that occurred in New York under his leadership. So again, it's great to have you aboard.

MR. STONE: Thank you, Charlie.

MR. CURIE: I'd like to turn it over to our co-chair, Pablo Hernandez, to facilitate Council discussion. Betty Duke is running late, so we're going to move up to Council discussion and any of the issues that have been

discussed so far. As soon as Betty arrives, we'll turn the floor over to her.

DR. HERNANDEZ: Thank you, Charlie.

Again, it is wonderful to be part of this SAMHSA transformation, because I think that this is great, the transformation of SAMHSA having so many great people about, Beverly and Kathryn and Jim and Charlie and Frank and Toian. This is a new SAMHSA. This is indeed a new SAMHSA. I think it's wonderful to have such a Council. The Council we have was caught out -- we have this leadership that we're going to have to keep burning whatever, or smoking the road.

(Laughter.)

DR. HERNANDEZ: I don't know which way we want to say it. My Latino phrases sometimes get tangled up with the English language and it doesn't translate too properly, but that's okay.

Anyhow, we do have a couple of things that we need to do later on, but let's get some reactions first, some comments to what Charlie and Jim have said. Anyone?

MS. SULLIVAN: There's something that I wanted to address, and maybe since we have the time, I'd like to. Charlie, I'd like to go over some remark, and if you could repeat it again, because there's a situation since we have the time that I wanted to bring up. This time is as good as any.

Here is my situation. I'm now a recipient of county services in the County of Riverside, and at $37 a pop, I get county psychiatric services, the best deal in town. As I personally walked in, the first words out of county's mouth, in front of everyone in the substance abuse and mental health services clinic, was "The first thing we want to tell you is we really don't have the funding for all of you here."

Charlie, the phrase was, "We don't want to miss the opportunity to treat these people who have finally walked in." Pablo, if I could, as we go through the next two days, I wanted to ask Council members if it would be appropriate for this Council to address what is now being fought over within the states and the counties, that we don't have the money to treat all of you.

It is my personal reaction as I have talked to people now who have found this in the San Bernardino, Los Angeles, and Riverside Counties, that this is the first remark that has been said to many people who are walking in for their first round of services. If it is appropriate for the SAMHSA Council to make a resolution to address this, I'm not sure how we are in the whole thing, how this can be addressed, because as you said, this is the group, the substance abuse people who are finally walking in for the first time, and this small number, if you said "It's a major factor, when someone is

ready, to find access," and to miss the opportunity -- I've heard of many people, after hearing this remark, just pick up their purse and walk out.

I would like in some way to either make some kind of resolution or what can we do to stop counties from making this remark within their mental health and substance abuse services, to address this to their clients. I feel it's inappropriate behavior, if someone is coming in for need -- you mentioned it, Charlie -- to miss this opportunity.

So what I'm saying is this is something I want to address in the next two days. Maybe it's the time, and you said it right there in your line, "to miss this opportunity." So I'm throwing it out here now, how we can do it. You know, you brought up in your thing. So that's why it pegged my interest.

MR. CURIE: Thank you, Kathleen. I think we can discuss it. First of all, you've identified the issue for the record already, which I think is a first step, and I think we can discuss what is the appropriate way of addressing this issue with states and counties. I think, again, it goes right to the heart of access when people come actually to the door. Basically, what are those things that facilitate engagement? What are those things, again, trying to sort out why exactly that message is being sent right out of the chute when someone

gets to the door. So let's put that on the agenda and let's have some sidebar discussions about what are appropriate ways to approach it.

DR. HERNANDEZ: Any other comments, anyone from the Council?

MS. HOLDER: Hi. I was going to wait until later to pass this out, but given Kathleen's remarks it might be useful to just get it on the record now. The National Association of Psychiatric Health Systems has conducted a survey of large employers across the country looking at behavioral health expenditures and how there has been a significant reduction in the dollars that are being used for behavioral health. Percent of premium has fallen dramatically, and it has had a great deal of impact related to people actually being able to access appropriate levels of care.

As we know, much of the funding for behavioral health has come out of the public system, but it's an unfair burden to have cost-shifting to the public system in such a dramatic way that I think this document represents. So if it's appropriate, we can put them on the table or however you'd like to do that. Thank you.

DR. HERNANDEZ: Definitely. That will be very appropriate. I think a lot of these two subjects/items we

will be able to discuss more specifically at the roundtable time, if that is okay with Kathleen and Diane.

Anyone else?

MS. HUFF: It will be brought back up later, right?

DR. HERNANDEZ: That is correct, Barbara. We will do that at the roundtable.

Not hearing any dialogues in this discussion, I would like to turn it over to Daryl.

Daryl, would you be ready?

MS. KADE: We're running a little early. I think at this point, since Dr. Duke is not here, we can take our 15-minute break and then return, and if she's here we can listen to her presentation or go to the next agenda item. I have about five to 10:00, so at 10:10 we'll reconvene. Thank you.

(Recess.)

MR. CURIE: Welcome back, everyone. I'm very pleased that Betty Duke has arrived. I shared with you earlier that HRSA and SAMHSA, we formed a very, very strong partnership to address issues around substance abuse treatment services and mental health treatment services in primary care settings. Of course, the community health centers are critical linchpins across this country in providing health services to the population across this country in various

states. We have the opportunity to do some model things.

I just want to say that Betty Duke has a long and very -- I shouldn't emphasize long, should I? -- but a stellar career in federal service. She has a tremendous reputation for being an effective manager, an effective leader, of doing the right thing. She's worked for four HHS Secretaries, I think starting with a fellow Hoosier, Otis Bowen. That's who you started with. I can tell you that in the time, the two years I've been in this position, I have really come to value very much the relationship with Betty and the trust of doing the right thing, of transcending turf, of taking a look at the individual and what's in the best interest of that person who comes to the door of services, and that's how I'd characterize Betty.

She's a no-nonsense, straightforward, get down to the bottom line person, and I think that's one reason we've been able to make such good progress in a short period of time. So I can't say enough good things about Betty and I'm just happy to introduce to you today the Administrator of HRSA. It's also historic to have the Administrator of HRSA at a SAMHSA National Advisory Council meeting, so this is a first.

Betty.

DR. DUKE: Thank you so much, Charlie. It's such

a privilege to be here. I want to apologize for not getting here earlier, but Charlie and I often accompany the Secretary on early-morning ventures, and when you're with the Secretary, he's like a rock star. Trying to get him out of a room is tough work. So not only are we there for his address, but then to try to help him get off to New York for his next assignment. So I apologize that I could not get here sooner.

But thank you for inviting me, Charlie. I am so happy to be here.

Charlie and I have been working diligently since we both arrived in these jobs two and a half years ago to try to see if we can't cement a strong partnership for HRSA and SAMHSA, because we're working with the same individual. I keep saying that my problem with the American system of health care is that we chop off the head and treat the rest, and that's comprehensive care, and in my book it is not. So we've been working very hard to include mental health, substance abuse, behavioral health in our work together, and this has been a partnership that has really blossomed.

My senior advisor, Steve Smith, who is sitting right behind me and was here earlier this morning, has been the team leader for HRSA in working with Charlie's team to see if we can't make the best bang for the buck out of what we are charged with doing at SAMHSA and HRSA, because, you see, both

of us work for the same constituency, which is basically a constituency which will not have care if we are not here.

The thing about it is how can we take the limited resources we have and turn them into the maximum possible care under the circumstances, because money does not grow on trees and we are charged with making really the best care decisions, and also making frugal decisions as well.

HRSA is positioned pretty well to be involved in this area. So I thought one of the things I might do this morning is talk a little bit about what HRSA does, because like most bureaucracies, we only know our little piece of it. I think as I talk very briefly about what we do, you'll see where there are so many crossovers, where Charlie's work and my work and why we spend time on the phone together, and why we come to visit each other's meetings, because our work does come together.

We really are a key safety net provider. That is to say, the people we deal with would not have care were we not here, and I'll illustrate that by our Ryan White CARE Act. Our largest program is our Ryan White CARE Act, which is $2 billion of the $7 billion HRSA budget. What the Ryan White CARE Act is really all about is the provision of care for persons with HIV/AIDS who would not have care were we not available. That means providing medication and other support

services to allow them to get better and to stay well, a major, major piece of our work.

We also have a responsibility for maternal and child health, and that is to ensure that babies are born well and that pregnant women and their children have access to health care. Our Maternal and Child Health Bureau is the oldest program we have. It goes back to the Social Security Act in the 1930s. But it is one that is desperately needed, because our future is there. How well we work in those areas is tremendously significant.

We also have the safety net program for the health centers, 3,400 of them right now across America, and this includes comprehensive community health centers, health centers for the homeless, and we also have health centers in public housing and in schools, and migrant health centers as well. Now, these are the real front line of primary and preventive medicine for the needy in this country. The President is very committed to expanding that health center initiative. At the beginning of the administration he committed to increasing the number of health center sites by 1,200 over a 5-year period, and we're working very hard along that goal.

He also committed to increasing the number of patients served, from 10 million at the beginning of the

administration to, in 2006, serving over 16 million people in that system. We're tracking pretty well. I always consider this a management nightmare, to suddenly take a system and increase it by 60 percent, which is basically what we're doing over a 5-year period. But we're doing very well. We're a little ahead of schedule. That is to say, we funded 171 new health centers last year, and we expanded services at 131 centers, and that's 41 ahead of our goal. We're still tracking to try to stay ahead of that.

This year our goal was 90 new access points and expanded services at 80, and I'm tickled that the Secretary last week announced grants, 204 grants, worth $56 million, to open new centers and to boost services, and to implement our health care collaboratives, and I'll talk about those a little bit in a moment.

But as you can imagine, we have been trying and working with Charlie and his staff, trying to change not only the number of health centers but the provision of services in the health centers. So in our new guidance for these expanded centers, we put in a requirement that they must bring up a mental health and substance abuse service component the day they come on board. You might ask, well, why have you done that? Just look at our statistics.

Mental health and substance abuse encounters

exceeded all other reported diagnostic categories in 2002, and from 1996 to 2001 the number of encounters for these conditions grew by 50 percent. So we know that this is an area where, in the preventive and primary health care arena, we need this step up. So we made that a requirement, and we're working hard at keeping the head attached to the body. That's the bottom line.

We've done some interesting things, and part of that collaboration that Charlie and I are working on here at the federal level we're also seeing worked on at the state levels as well. In South Carolina, the Primary Care Association developed a model of partnership in which the Richland Community Health Center Association in Columbia worked with the Family Health Center in Orangeburg, and they've developed a comprehensive package of care through exchange of staff. When budgets get cut, which happens, they have worked out a plan to partner to make sure that the behavioral health professionals do not leave that community, so that they are still there and still able to provide the services that are needed.

In Lowell, Massachusetts, the Southeast Asian community has worked to create a culturally competent mental health and substance abuse program which is really a model. They put together an integrated model of culturally and

linguistically appropriate care by combining primary care and Cambodian traditional healing, along with meditation, mental health services, acupuncture and massage therapy, all at one site -- one-stop shopping at its best -- and they called it the Meta-Health Center.

Something that would be appropriate for me, the Over-60 Health Center in Berkeley, California integrates mental health, substance abuse, and primary care services so that the consumer doesn't have to travel and the stigma is not available. This is the first, and I think the first of what will be a trend, geriatric health center in America. The Over-60 Center recognized the need to have mental health, substance abuse, and behavioral health services integrated into their package from the day they opened. So we think this is a big step forward, and I know that this is something that the chairman of our subcommittee will be very interested in, the ability of Charlie and me to make this collaboration happen, because our chairman is dedicated to the idea of improved comprehensive services for geriatric patients.

I mentioned a little while ago about our health disparities collaboratives. These are approaches to care that are designed to bring people the best possible care in a culturally sensitive way. When we started out, the collaboratives dealt with diabetes, asthma, and depression.

What happened over the years was the recognition that depression was co-presenting with so many other of the chronic diseases that we were working with, because as we expanded to cardiovascular diseases and our first collaborative on cancer -- we have 12 pilot sites working on three forms of cancer this year -- one of the realities is that depression is part of the problem.

So we've changed our approach and we now have built that in. Again, we've been working with Charlie in this area because we're trying to change the way we care for patients, and we believe we have the data to show significant improvements, because the collaboratives work on the idea of the very best solid science base for the care, and we do that in collaboration with NIH. That's been a really wonderful partnership. For example, in developing the 12 cancer pilots this year, NIH and Andy von Eschenbach at the Cancer Institute have really pitched in to make sure that when we have a learning session for our cancer centers, they send us the best faculty they've got. So when they go back to their health centers to initiate this approach to cancer treatment, they've got the best, most current science to start with.

It also rests on the idea that we need to change the patient's involvement in his or her own care, and that means getting them involved in managing their own illness, and

particularly in the diabetes collaborative, we've had tremendous success because the changes in behavior that are required really are supported by individual as well as group involvement. For example, in our collaboratives, we bring the community in to help us. So we have as part of our collaborative, we have some cooking classes.

Now, you may not see this as something that a health center ought to be doing, but think about it. You are what you eat, and trying to change the way people think about cooking, in fact getting not only the patient but the person who cooks for the patient, if the patient is not the cook -- I know this very well. I tell this story because if left to my own devices, I would be a blimp, and I know that. Unfortunately, I've had to battle my whole life, and I remember when I was a young fiance, about 40-some years ago, and I was invited to the home of my then-fiance from the Mason-Dixon line southward, and mothers-in-law are as nervous about meeting potential daughters-in-law. You've been there, some of you, I suspect.

So, of course, she was putting her best foot forward, and I knew I was in big trouble. It was the most fabulous dinner. Oh, it was so good. Yes, you all know what's coming. It was smothered fried chicken, mashed potatoes smothered in gravy, and it was peas and corn

succotash. And I'll tell you, it was great. But I knew I was in trouble, because if that's what he was used to eating, I was going to have to produce some major changes, which he graciously consented to, and we managed to get through 38 wonderful years.

Well, having said that, you can see that we recognized that health care is a total commitment, that we've got to get the community involved, and we work hard at that.

So one of the things that we recognized is that we can provide cooking classes. We can also provide services for mental health as well. So one of the things that Charlie and I have been trying to model is that what people want is a good life. They don't want to be a patient. They don't want to be a statistic. They want a good life. What Charlie and I are trying to do is to humanize these systems to say we can do this together, and it's the creative potential of getting folks who care about other people involved and working together, and that's what we're about.

One of the things that we've tried to do is we actually have put out some publications. We have a publication that is actually being used worldwide, which is "A Guide for Clinical Care for Women with HIV," and it was the first time that such a comprehensive book was put together. They're now using it in Africa, for example. They're also

using it in the Caribbean. But it's a clinical challenge, because so often the woman in care is also a caregiver at the same time and dealing with psychological problems, the financial problems and logistical problems, and our book really deals with the idea of how are we going to provide that kind of support for them.

We try to be pretty practical about what we do. Everybody uses words like "down to earth," "the bottom line," "no nonsense." Well, I actually believe that's exactly what our products ought to be. It shouldn't be just their mouthy director but at least should be practical. We should not be overwhelming people with technical discussions that look good on your graduate school vitae but they don't do much when you're trying to deal with a heavy patient load and a lot of work to do.

So we've been putting out some very practical, easy to read, helpful guidance, and Charlie's group has been very helpful to us in this way. We've put out some practical stuff from our Maternal and Child Health Bureau, mainly dealing with kids and adolescents and the question of how do you work with them. You know, we were them once. We aren't anymore. It's a challenge, especially to those of you who are dealing with them in your own living room. Dealing with them professionally is even more of a challenge. Well, that's not

true. Dealing with them in your own living room is actually more of a challenge.

One of the things we did is we put out some practical materials such as how to deal with unfavorable attitudes of teenage patients toward mental health providers and the whole issue, the stigmas and the myths. So we think that's practical stuff that people need. We also put out some material on suicide causes among teens, because we think we really need to start facing some of those realities. Charlie and I are just about to launch some emphasis on dealing with bullying, because this is a tremendous problem in America. The statistics are horrifying. I suspect again, both personally and professionally, you've dealt with these issues, because three out of four teenagers, at some point in their life, have either been a victim of bullying or a bully, or both, and it is common that they're both.

So we're concerned about the issues, and again Charlie and I have worked together on that campaign. So we believe we can get America's attention to this issue. So we're committed, and if I could just make one last pitch on this, Charlie and I need your help because we're sitting here in Washington, although I must say Charlie and I spend a lot of time sitting on airplanes.

But when we're out and about, we're learning from

you and your peers. People always assume that George will do it. George is going to pick up the phone and tell us where there's a problem. But Charlie and I can't intuit it. We need your help. We need you to tell us where there are problems, and then we will commit to working together with you and with the communities on those subjects. That is a commitment that Charlie and I have made from the beginning. We're comfortable with each other and with our teams. So if you would help us, we think we can do a better job.

Thank you so very much for inviting me. I'm open for questions and dialogue and discussion, and I'm here until you tell me to go home.

MR. CURIE: Thank you, Betty.

One thing I might add in terms of our collaborative efforts, as Betty has described, the essential nature of mental health and substance abuse capacity and linkages in the community health centers is absolutely essential. The data support it, as Betty just shared. All of us in the field know it's true. The data continue to reinforce that, and we have been able to move ahead in a collaborative way to see how this can be translated at the state and local levels.

NASMHPD, NASADAD, and Charles, the Council, providers associations have been working with HRSA and SAMHSA

to talk about different ways that we can accomplish that capacity. As Betty indicated, there is a workforce development crisis in the health care field overall, and substance abuse and mental health are very much in that fray of the crisis, recruiting people and retaining people in the fields. If we can find win-win situations locally for community health centers, community mental health centers and community-based drug and alcohol centers can connect together -- and there are examples of that across the country, and we're trying to bring that more to the scale to look that there's more than one right way to do certain things.

Again, I think it's an example. HRSA has been actually willing and did put bonus points in for such collaboration efforts in their grants. Again, that's almost unheard of, when you think of how operating divisions have operated in the past to reach out. So again, I wanted to give that as a concrete example and thank Betty publicly and HRSA publicly for that ongoing collaboration and working with that process.

Let's open it up, Pablo.

DR. HERNANDEZ: I very much appreciate Dr. Duke's comments, as well as Charlie, in reference to the collaboration. I think most of you read USA Today, and you should look to -- I always have a habit, I look to the left

lower quadrant of the newspaper to see what's new. Again, today was another reinforcing article about physicians. The time the physician spends with patients in the United States, 60 percent basically spend less than 15 minutes with a patient today. That's either an improvement or we're going backwards.

I remember years back when we used to say it was eight minutes. Now it's 15 minutes. So it speaks to the importance of us to be able to look at how do we bring other allied professionals to participate with decisions, especially when we're going to be talking about not only the primary care entity and care but also the mental health and substance abuse. What can we do in reference to collaboration and engagement? I mean, depression is a major issue for all of us, and the question is can anyone really address depression in a 15-minute visit. Excuse me, but if you're talking about older adults, it takes at least 45 minutes for me to even start thinking about my depression, how to ventilate it out, because it takes me a while. If I get somebody there pushing me too much, then I start stuttering, and then I get defensive.

So I think we need to look at how do we engage in a different world, because it's totally the engagement is different, the co-location, the integration. I think too often community mental health centers, for example, have not

had an emphasis on primary care. I mean, I would dare to offer that there are very few community mental health centers who have a physiological health care attention, and still we are prescribing much medication to individuals, not recognizing the physiological conditions of those medications.

So I think it's good that we talk, and to me it's a major crisis that needs to be addressed in the nation. We can talk about Medicare is going to do this, but who wants to be a Medicare provider for mental health? I mean, who wants to? You don't get paid. So I think we need to talk about changes, and it's encouraging to see not only the dialogue but the actual partnership that exists between HRSA and SAMHSA. So thank you very much.

DR. DUKE: Let me comment a little bit on that statistic, because it is a worrisome statistic. One of the things we're doing in the collaboratives is we're actually trying to change the way we deliver health care. In the full implementation of the care and practice model that goes with our collaboratives, what it involves is actually developing a team practice, and I'll cite a center in Denver that has really changed the way we do health care.

When the patient walks through the door, there are two people on the front desk, and you either go to the purple team or the orange team. At that point, you don't sit

in the waiting room. You go to an examining room, and the examining room is the only place you go as a patient, and then health care comes to you in the form of any eligibility requirements, any paperwork that has to be done, x-rays, blood tests -- you name it, it all comes to you. What they've done is a lot more cross-training.

In terms of time with the physician, they actually get more time with the physician. I think they're now up over 20 minutes with a physician, but they've also reduced the amount of time the patient is on the premises. I think they're down to 47 minutes cycle time. That is, from the minute they walk in through the door until the minute they walk out through the door, and about half of that time is spent with the primary care provider.

They also do group visits, for example, with their diabetes collaborative. They have some group visits and, for example, they've hooked their cooking class -- they do have a cooking class -- to that time so that they're trying to increase the value of the time and to do cross-training across that team. Their ultimate goal, by the way, is to get rid of their front desk. Right now their front desk works in the morning at the front desk, and then they've cross-trained them to do some other work assisting in the afternoon. Ultimately, the goal is you come in and you're told that

you're going to examining room 3, and when you come in examining room 3 is supposed to be open.

They're very adventurous in this and, I think, wise.

DR. HERNANDEZ: I think Ms. Huff, and then Dr. Pepper.

MS. HUFF: Well, I'm just so thrilled to meet you, I can't even believe it. My name is Barbara Huff and I'm the director of the Federation of Families for Children's Mental Health. I'm the parent of a daughter who has had mental health problems since she was very young. She has anorexia and serious depression and has struggled with co-occurring substance abuse, cocaine problems. Then I also have a daughter 18 months older who has the most aggressive kind of breast cancer known to mankind. So I had an interest in everything you said, obviously.

But I just have to tell you that I was in Senator Inouye's office last week with his chief of staff, Patrick DeLeon, and he said to me, "I just think you're barking up the wrong tree with SAMHSA." He said, "Not that I don't like SAMHSA," but he said, "You have got to go to HRSA and meet Betty Duke, because the two of you have such innovative ideas about how to do business."

DR. DUKE: So does Charlie.

MS. HUFF: Yes. So anyway, I said, you know, I'm not done with SAMHSA yet, but I will go over and meet her. Well, the last words going out of his office -- I was there talking about Foundations for Learning and young children and early intervention and like that. Well, anyway, the last words were, "You've got to promise me you're going to go over and meet Betty Duke." So I can't even believe I've had this chance. So I just want to tell you today how much I appreciate you coming over.

DR. DUKE: Thank you.

MS. HUFF: I think the Federation could be probably a wonderful disseminating place for all the stuff on bullying, because we have 150 family organizations across the country that are all run by families of children with mental health problems. So just know that we'd be happy to help in any way we can in disseminating yours and Charlie's innovation and all the information on bullying and all of that. I just want to say that we do packets of information that go out, and we have a website to try to keep families well informed. So I want to be able to do that.

I also have an 87-year-old mother dying of cancer right now, and I've watched the depression with her. But I must tell you that hospice and others have been incredible in bringing mental health to her right in her home. So that has

been really, really wonderful.

So I've got it kind of in all aspects of my life right now, so it's kind of a tough time and a tough place.

The question that I have for you, now that I've said all of that, the question that I have for you is are the health clinics in schools, are they yours? Do those come out of HRSA?

DR. DUKE: Not all health centers in schools are HRSA-supported health clinics, but many are, and they're supported under two different programs. Many of the clinics in schools are associated with our consolidated health centers such that they might have a health center on Main Street, they might have a health center out in a rural area nearby, and they might have either a part-time or a full-time clinic in a school. If they do have a center in a school, they are likely to have some substance abuse or mental health aspect of that program.

By the way, those are very demanding jobs. They are incredibly demanding.

We also have other programs that are supported out of our Maternal and Child Health Bureau as well.

MS. HUFF: Thanks. Thank you, and again, it's really nice to have you here.

DR. DUKE: Thank you. It's wonderful to be here.

DR. HERNANDEZ: Dr. Pepper?

DR. PEPPER: First of all, I'd like to check your credentials, because you sure don't sound like a bureaucrat to me.

(Laughter.)

DR. DUKE: I've been fighting it all my life.

DR. PEPPER: But seriously, thank you so much for your very exciting comments.

I want to make a comment that I think puts together what Pablo said about doctors' time, and I noticed that box this morning also, and you beat me to bringing it up here today, about how little time doctors have, because for years a former member of this Council who was, at that time, the president of the American Medical Association, whenever we would get to the discussion about why aren't physicians screening for substance abuse or mental health, he would go like this and he would hold up six fingers, and he would say "That's how many minutes I have as an internist in my Virginia practice to see each patient."

So we have now more refined data from the newspaper. It's actually 60 percent have less than 15 minutes, about 25 percent have less than 10 minutes, and nobody's got an hour anymore, except for those psychiatrists like myself who are able to be outside of the insurance

system.

And yet, let me go back to some research that was originally done in the 1960s and has been reiterated again and again and again. The most potent healing force between a healer and a consumer consists of two elements. One is a shared value and belief system, and the other is a relationship, an attachment, a trust-attached connection. We all know, for example, that adolescents have a lot of trouble relating to adults, not just their parents and their teachers. How do you get a 13-year-old who is in trouble with, let's say, her anorexia, her bulimia, her drug use, her peer relationships, to walk into any adult's office and make a relationship when there's no time and there's no opportunity to find out if there's a shared value and belief system?

DR. HERNANDEZ: Well said, Bert.

Lewis, do you have a comment to make?

DR. GALLANT: Dr. Duke, I'm Lewis Gallant. I'm the executive director for the National Association of State Alcohol and Drug Abuse Directors.

DR. DUKE: Nice to meet you.

DR. GALLANT: We are the folk who deliver publicly financed substance abuse prevention and treatment services within state systems.

I wanted to ask, in terms of the mental health

substance abuse component you're talking about in the health centers, are those outsourced, or are you bringing staff in, or is it a combination thereof?

DR. DUKE: All of the above. As Charlie and I wrote the guidance this year -- actually, that was quite unprecedented for two agencies to collaborate in writing the guidance for a program, but that's what we did this year. One of the things we tried to say is where there's an opportunity and an already-existing service, to partner and see if you can't reinforce each other's services. In some cases they have contracted out, in some cases they've hired staff, in some cases they're sharing staff, because, you see, staff are very few and far between. So we have to do a lot of creative managing.

In fact, actually, I will say this, and I'm sure that Charlie finds this in his world as well. If the people who ran our health centers chose to be in private corporate America, they'd be very rich because they are creative managers. I'm always impressed with the way they can glue together pieces of staff and pots of money, a little bit from Charlie, a little bit from me, a little bit from the county, a little bit from the state, to put together some programs. I am amazed that they do as well as they do.

One of the things we do is we run the National

Health Service Corps in HRSA, and HRSA is a very, very multifaceted agency. We provide scholarships for folks to go to school, and then they pay us back by taking work assignments after they finish school, or we provide for graduates' loan repayment services and we recruit across the spectrum in that area as well.

DR. HERNANDEZ: Thank you very much.

I just want to make an announcement for the public. There will be time for public comments. I think this is a major issue, the structural health in the United States. So I just want to say to the public we will be taking public comments and we will have ample time to have that dialogue after another presentation later on by Dr. Sullivan. But let's keep the dialogue.

Any other questions from the Council, please?

DR. DUKE: I should make one comment in addition. I've talked a lot about our service side. I haven't talked about our resource side very much. We do run the Bureau of Health Professions, so we make a series of grants to schools to increase both the availability of health professions across the 270 health professions and to ensure their racial and ethnic diversity, as well as in their ultimate placement, their geographic dispersion across the country. That's actually a huge program, with about 1,700 grants going to a

variety of different kinds of schools -- medicine, dentistry, psychology. I mean, we're across the board. We have allied health. Every once in a while I check my alphabet soup to see what isn't there, but it's almost all there. So we do that as well.

DR. HERNANDEZ: Dr. Gallant?

DR. GALLANT: Are substance abuse counselors or professionals included in that?

DR. DUKE: The legislation that undergirds each of the programs is quite specific. So in some of our programs, substance abuse counselors might be included, social workers might be included. In others, there are different mixes. That's always one of the challenges. Whenever one of those programs comes to brief me, I always have to start with, okay, let's go back to basics, what does the law say? So the law lays out the basics, and then we go from there.

DR. GALLANT: Charlie mentioned in his comments this morning prior to your arrival, and I think he also indicated in his introduction of you, that our field is in a crisis in terms of workforce development. It's truly an area that, with all the President is trying to put into our system in terms of expanding capacity, capacity can't expand if you don't have the workforce to underpin it. You can get all the money in the world, Congress can say we're going to give you

billions to close the gap, but if you can't have the workforce, it's not going to happen.

Can we in some way create an initiative within HHS or within HRSA, or in collaboration with SAMHSA, to really take a look at this workforce issue and how we can get a handle on it? Because I think if not, we're going to be in a crisis because, particularly in substance abuse, counselors are finding it difficult to live on $25,000 a year. They're also finding it difficult to educate themselves on $25,000 a year. Nobody is offering them anything in terms of scholarships or anything to educate themselves.

So if I could become a computer programmer and make $70,000 a year, my heart may be bleeding to be a behavioral health person, but my wallet will say do the other thing. So unless we can deal with compensation, unless we can make the field more attractive, unless we can provide the resources and the access to training, we're going to be in a real serious situation in the very near future.

DR. DUKE: There are two aspects of that. One is the issue of compensation, and one of the things that we've seen in the nursing shortage, and I'll illustrate that, is as the nursing shortage has become more acute, economists would tell us that to increase the supply, you'll increase salaries. As salaries have gone up for nurses, one of the problems we've

had is it siphoned off the nurses who are available to be faculty, because faculty salaries have not kept up. So I'm constantly on a campaign to recognize that we need the faculty salaries to go up in order for nurses to maintain themselves in nursing positions, and I keep trying to advocate for flexible arrangements, joint appointments where perhaps we could increase the pool of faculty and also at the same time increase the practical education, which I happen to believe in as well.

So we recognize that the compensation issues are very large, and that was one of the discussions we had when the Nurse Reinvestment Act was passed, how are we going to maintain the development of a nursing cadre at the same time that there are so many pulls in the opposite direction. So the compensation issue is a very real one.

The other is a dilemma of even if you can compensate folks, they've got to know that that field exists and that it's a possibility for them. One of the things we're working on -- I'm going to illustrate this with three things.

We have a program in our health professions world, the Health Careers Opportunities Program, that actually gives grants for reaching out to fill the pipeline. That is, to reach down not just to high schools but even into elementary schools to try to get people involved, and

particularly to reach into our minority communities.

We also have a program called Kids into Health Careers. Again, it goes back to Dr. Pepper's comment about adults not talking to kids. One of the things in that program is they actually built a little toolkit for people who go to talk to kids about talking to them in an age-appropriate way. So it actually has stuff for kindergarten kids and 8th grade kids and 7th grade kids and 12th grade kids, so that when we go out and try to talk about life in the health professions and why that might be for them, we might do that in an interesting and age-appropriate way.

One of my favorite things that I've done in this job was I took a small grant of $141,000 -- now, that is not a large grant when you're giving out $600,000 here and there. I do not subscribe to the view that soon it becomes big money. All money is big money to me. But this was a relatively small grant, and I took it to a school in Texas, and a faculty member started a program for nursing education. What she did is she reached down into the community to find those people who did not see themselves as college material.

She got herself an advisory committee made up of leaders in the community, and she literally went out and grabbed them by the collar and dragged them into school. Her first class had five students in it, and she's graduating all

five of them, and the valedictorian of that class is already accepted for a Master's program in nursing. She never saw herself going to college.

The second year of the program she got herself another $5,000 and recruited another five students. Then she got her first class to help her write the grant, and they told me that grant writing was very hard to do. I said, yes, indeed it is, but aren't you something? On their first attempt, they landed a grant from us for $141,000, which is going to take that program a long way.

Now, I am a teacher at heart and I empathize with that. The commitment of this woman -- forget the 60-hour week. I had no idea how many hours a week this woman puts in, but she works -- by the way, her whole advisory committee showed up to receive the award, and these are people who take off work and don't get compensated when they take off from work. But they all were there, and all of the students were there, and I must say, to his credit, the head of the health science center was there to receive it as well. It was a real accolade for this teacher.

What that gets to is this point that part of what we have to do in this nation is we have to recognize that not every young person in America has a built-in role model, and we have to go out and create those role models. We have to go

out and work. You know, this is a four-letter word, but it is the essence of it all. We have to work. We have to work hard at getting across the message that you can be more than your immediate dream. You've got to get out there and do that.

Then my last comment on this was that I was getting dressed the other morning and I heard a most encouraging thing on NPR. They said in this economic downturn, some previously overlooked professions are suddenly getting a second look, and that included our world as well as teaching. So I do think the compensation issue remains a central one, but there are other pieces.

DR. HERNANDEZ: Thank you, Dr. Duke.

I just would make one comment, that as the efforts are made in the field of health care and development of workforce, that the issue of cultural competence be manifested, not just the issue of recruiting minorities. Myself, am I a culturally competent Latino? That would be a question. I might have a linguistic capacity, I still might have a funny accent, but does that make me culturally competent?

So I think we have to be thinking about how do we get whatever we prescribe is culturally attentive, culturally competent to whatever population we serve across the age continuum. I think that as health centers move into the

dialogue on behavioral health, I really encourage more and more the partnership on cultural competence that exists within SAMHSA. I'm hoping that HRSA, again, will follow that through.

Anyone else?

DR. PEPPER: I just want to talk about recruitment, a flipside to the very important point you made about the ability that we have, if we think about it, to motivate minority children to complete their education and go into human services.

I served as the consultant to a program for advantaged high school students in a very wealthy area to work a whole summer when they were 16 in an institution for the retarded, in another institution for the physically handicapped, and in a psychiatric hospital. At the end of the summer, these advantaged kids said the following: This is the first time in my life that I felt I was important to anybody else, that I was a useful person. So that's the flipside to the recruitment issue of children or adolescents.

DR. DUKE: Wonderful, wonderful. A wonderful corrective, yes.

DR. HERNANDEZ: Ms. Huff?

MS. HUFF: The Council never lacks for passion as long as we've got Bert here, you know? Dr. Pepper. Thanks,

Bert.

Just a couple of really quick things. First of all, I want to clarify that when I went into Inouye's office, he thought I was coming around for Starting Early, Starting Smart. I said no, I was there around Foundations for Learning, which is out of the Department of Education. He's always used to hearing me talk about SAMHSA and not the Department of Education. But anyway, he thought it would be good if we forged a partnership, after we had this conversation, not just with Education but with SAMHSA and HRSA around Foundations for Learning, because it's little kids. I'll talk to you some other time about that, because it would be an interesting partnership across Education and HRSA and SAMHSA, actually, around little kids.

Actually, it came out of Patrick Kennedy's office, and the legislation was passed about a year ago. Anyway, it might be an interesting way to forge another partnership, but he wasn't saying anything bad about SAMHSA, he was just saying he's used to me being there around SAMHSA, not around the Department of Education. Anyway, Trina Osher normally does our work around the Department of Education.

But again, I want to thank you for your innovation, and I also wanted to just kind of -- I don't know what physicians think about this because I really haven't had

a chance to ask, but I know that HRSA did -- when we're talking about workforce issues, you did for physicians, family physicians and other general practice physicians a document called "Bright Futures" on mental health. It came out of your department, and I have not seen it as widely spread as I'd like to, but I'd like to see what you think about that.

It was done in a collaborative effort between physicians and people in the mental health arena for physicians that see kids in their office that have mental health problems. They have a toolkit, actually. So anyway, again, it's something that I don't think is out there maybe like it should be, but I know it's there, because we helped a little bit with it.

DR. DUKE: Great. I'll check into it.

MS. HUFF: Thanks again.

DR. HERNANDEZ: Ms. Holder?

MS. HOLDER: One of the things that I think folks have been able to do through the federally qualified health centers and some of the programs that you've had is there's been a capacity to have a little better reimbursement for getting some additional mental health capability in the centers, which I think is a really good thing. One of the questions I would have, though, is that I work for an organization that for about 20 years has had a primary care

center sitting in the middle of our services for the chronically mentally ill. Typically, these folks have a lot of trouble going to primary care centers. They haven't been particularly well treated in primary care centers.

We have been able, for the last couple of decades, to have really tremendously positive results for diabetes management and cardiac hypertension conditions, et cetera, but we don't find any comparable enhanced reimbursement on the mental health side. I've not heard people talk about this, but if you have these large community mental health centers where there's really a population of folks who have a trust and a confidence in getting their care there, would there be potentially a way that instead of the primary care place being the only center for people who need help can get it, could we think about some kind of funding methodology, or is there such a thing, that would enhance bringing primary care into the mental health setting?

DR. DUKE: The issues around reimbursement get us into a series of relationships. Often we're dealing with CMS regulations having to do with Medicaid, and then there are the 50 state regulations which are also state unique. We do work with CMS. In fact, we've just written to CMS on the subject of reimbursement for mental health services. It is a continuing challenge, and I will say that we've had good

working relationships at the staff level and we're aware of these problems because they come up everyplace I go. So we're aware of them and we're trying to find some routes to cut through some of the difficulties. But I'm aware that they're there.

DR. HERNANDEZ: Well, I think we need to thank Dr. Duke. Definitely, we would love for you to stay with us, if you can. I think it's very exciting to have you here.

DR. DUKE: Can't. I just got my orders.

DR. HERNANDEZ: But we just want to say thank you so much for being here with us and giving us so much of your time. We will be visiting with you again.

DR. DUKE: Thank you very, very much for having me.

(Applause.)

DR. HERNANDEZ: I would like to turn this over to Ms. Kade.

MS. KADE: Thank you very much.

We're going to resume our agenda, and we'll cover both items. We'll try and cover both items. The next item is a follow-up to material that you were sent on our standard funding mechanisms. Dr. Frank Sullivan and Ms. Jennifer Fiedelholtz will be doing the presentation on these mechanisms for you. Thank you.

DR. SULLIVAN: Good morning, everyone. I appreciate a chance to come and give you an update. If you were here at the last Council meeting, you heard me give an overview of a number of the management initiatives and reengineering activities that we've been engaging in at SAMHSA, and I'm here today to give you an update on one particular one of those that is moving out into implementation in 2004 that we expect will have a big impact on both our operations and we think will also be beneficial to people who want to apply to SAMHSA for grants and, once they have a grant, to figure out how to work with us and us with them.

This presentation is focused on the new standard grant mechanisms that we now have out for public comment. I'm going to go as quickly as I can because I know we're trying to make up some time, so I'm not going to read the slides to you. You have a handout, so I'm going to give really an overview and hope you can sort of track with the details as I go along.

I always show this at the beginning of a presentation such as this, and the reason is we do have a plan. This is our strategic human capital plan, and it is broad in concept. It covers clarifying organizational purpose, creating effective work processes, which is what this particular project is about, and valuing our most critical asset, people. I need to reinforce a point that's been made

several times already this morning about Charlie's leadership. The efforts we're engaged in really step off from the green box up there, clarifying what SAMHSA is all about. If you don't have that, you can't go on too much into the red and the blue, although we are working in all three of those areas.

We have been working on reengineering the discretionary grant process in the agency. I'm accompanied here by Jennifer Fiedelholtz from our planning office. Jennifer is one of an 11-person self-managed team that was given the charge to do something about this last October, came back with a solid plan in February, and have been working autonomously, with some help from management as need be, but with a lot of self-directed leadership from across the centers and the front office, and they've really done a superb job. In addition to the outcomes that we're getting, we're really proud of staff being able to work in this very self-directed and self-motivated way.

I won't go into the details of this. You have seen it before. If you multiply this by three to cover three centers, and then multiply it by 10, this is probably only a tenth of what our process is to get a grant program announced, out the door, awarded, and so on and so forth. I just put this here to give you a sense of what we are up against. This will be tackled by our internal processes, streamlining them

very significantly.

Here is the overall concept, which involves three things: standard grant mechanisms, and that's the purpose of my presentation this morning, to go into that in a little bit more detail and let you know that these are out for public comment. The other two parts of this are getting our internal act together, earlier and simpler policy review and decisionmaking; and the third leg of the stool is a reengineering of the application review process, which I will come back to at the end of this presentation.

Here is what we are aiming for, our purpose and goals when it comes to the standard grant mechanisms. We hear all the time from applicants, from grantees, that SAMHSA announcements are hard to read, we can't figure out what you're doing, why is this one different from that one, where's the fine print. They're not clear. We need to do a better job of being clear with applicants and grantees as to what it is SAMHSA wants to achieve, in essence to purchase in its grant programs.

We hear the same kinds of questions up the line. We're constantly explaining to the Department, to OMB, to the Hill what does SAMHSA do. So again, we have a communications and a clarity issue on that end.

We're also going to be extending out the notion

of the announcement into the kinds of measurement and the kinds of data that we would like grantees to collect so that we can answer and be accountable in the many forums in which we have to be accountable for results and outcomes and the question why should we give SAMHSA another dollar. So we hope to increase our energies and our efforts to deal better with that.

We think this will be of great service to the field. Things will be more predictable, and we are hoping to achieve process efficiencies. I have to tell you, this is the number-one source of wasted energy in the agency at this point on every list of what's wrong. This is number one. So we hope to get this one nailed down pretty well next year, and we're already starting on number two.

Finally, simplifying and going into standardization will help us meet our requirements to support the President's management agenda with regard to e-grants, e-government, electronic everything, and I'll refer to that a little bit later also.

Here are the core ingredients of our standard mechanisms. We are proposing four mechanisms to support the delivery of services, the development and implementation of infrastructure, looking at best practices for planning and implementation, and moving service into science. One of the

pluses here is that we see this as a full-scale approach. We usually have been focusing in on the science-to-service front of things in the sense of here's the science, here's the result, let's put it to service. Our fourth standard mechanism is saying let's take what we know from the service side of the house, spiff it up and get it ready for more thorough evaluation by the research institutes. So we see this as a sort of comprehensive approach.

A place for everyone at the table. These mechanisms cover 75 to 80 percent of all of our current grant announcements. So by and large, you will fit in, and if you won't fit in, we'll let you have an exception.

We are also providing a flexible menu for grantees from which they can choose what it is they want to seek support for. I mentioned that we're looking into refining and signalling early the outcomes and measurement requirements. We intend to link the standard mechanisms to the funding priorities of the agency on an annual basis, stepping off from our budget, by very brief notices of funding availability. I'm a tad nervous about this. I used to say it was one page, and then I was told to make it one or two, and now I'm told to make it brief. So I'll say that if you're on the team or anywhere else in SAMHSA, three is tops.

Let me describe briefly the services grant

mechanism. The purpose is to provide more services to address gaps or to increase applicants' ability to meet currently unmet needs with respect to specific populations or specific geographic areas. What we are defining as services is presented on the paper. You'll see what's there: outreach, treatment, wrap-around. We'll allow grantees to spend up to 20 percent of the grant for data and up to 15 percent for infrastructure, if need be.

A key part of our approach here is to reinforce and advance the agency's objectives to promote evidence-based practices, good services that have a strong knowledge base. So that you'll see in the services grant and in the best practices grant. The quote there is for the best objective information, and we will continue to have this determination made by peer reviewers who will be looking at applications.

Lastly, this was a surprise to me, I have to admit, although I've heard a lot of griping about grantees getting grants and nothing happening for a while. You need to be ready to get the services in the field after four months, four months after you get the award. So we want to stress that if you're getting a services grant, the idea is to actually deliver the services, not to plan to deliver the services at some point downstream.

Next is the infrastructure grant to increase

capacity of systems. I would call your attention to the fourth tick under "Examples", workforce development, and we've heard a lot this morning about workforce development. So we have a place here for people who want to do infrastructure work on workforce. They will obviously be fitting into this announcement. Here we'll give them 15 percent of the money to actually implement and check on the utility of the infrastructures that they are putting in place. But the name of the game here is to provide support for the kinds of things that are illustrated there.

Best practice planning and implementation. This is to identify practices that can effectively meet local needs, develop plans to implement them, and pilot test them. Again, we have the same sort of approach to the evidence base. These grants will have two phases, the first one being to do the planning and the preparation, and the second phase to be doing the actual pilot test and the evaluation.

Turning now to service-to-science, which gets a lot of questions usually, here the idea is to document and evaluate innovative practices that address critical service gaps but have not yet been formally evaluated. There is a piece of important small print right under that. These grants will not be intended to support the development of entirely new service approaches or new practices. There has to be

something out there reasonably developed. The purpose of these grants will be to take that state and advance it to a more sophisticated state that would allow us to say this has sufficient promise to be recommended for more thorough evaluation and join into the evidence on its way to becoming part of the evidence-based practices in the field.

I'm returning now to the other two elements of our plan. The first one here is earlier and simpler policy review within SAMHSA. We have already done our up-front planning for the coming year, and our approach to this is we have been doing planning on things that are in the President's 2004 budget request. So a lot of the notices of funding availability, et cetera, are in the can, sort of ready to come out.

The word to ourselves and the word to people working on this is if your program is not in the President's budget, you really shouldn't be making plans or spending your time developing a grant announcement, because we're moving from the budget very clearly into implementation of the budget. I'll come back to that. This is one of the key elements on the President's management agenda that we believe will be significantly advanced here.

On the expected outcomes, you see a lot of good things: comprehensive planning, which I just talked about.

Go down to the fourth bullet there, reduced handoffs. We are going to reduce the number of times a piece of paper or a document, be it electronic or paper, goes from this one to that one, back to this one, over to that one, back to that one -- the rainbow chart. So that's what we are looking to do, and this is very much under our control. So if we fall down on this, you will have no one to blame but SAMHSA.

The reengineering review. We talked about this in some depth last time. We're going to emphasize more front-end triage, especially where there's high-volume applications with an expected low number of awards as dictated by the budget funds available. We are going to be ensuring that there's a tighter programmatic link between the program side of the house and the application review, more teleconferencing, technology support, and we are in the process of shifting this operation, which now has a good deal of contract support, to a competitively sourced operation in 2004.

I need to take a moment at this point to say we are very optimistic about where we are on all of this. We are not naive, and we believe that 2004 will be a major crunch and transition year for SAMHSA as movement on all three of these fronts -- what we do, what we say we want to buy, and how we review the applications -- ratchets in bit by bit. So we'll

have a lot of scheduling and linkage issues to deal with this year, but we are convinced that the bottom line will be more than worth it.

Here's what we think we need to let go of, and this is mainly a SAMHSA thing. A lot of internal turf, a lot of changing views of what the mission and the policy are of the agency, and I hark back to my earlier comments at the beginning. If we don't have the vision and Charlie's leadership on mission and policy and where we're going, yes, you're going to have a lot of changes because nobody knows quite what it is and you'll try to make it fit. Now we have a tighter framework for what will and won't fit.

The notion that we need to reinvent every program every time; and our supreme failing in the management channels, at least in this part of the SAMHSA organization, the temptation to change the rules all the time. I hope we will get to where, yes, a deadline is in fact a deadline. We are not the only organization, as I'm sure you know, in the world that is facing this particular kind of challenge, and I'm sure it's an endemic sort of thing.

Here's what we hope to gain, if I may just wrap up because I'm at the end. A shared vision internally and externally. You will know what we're doing, we will be communicating with you, and when you talk back to us, we will

have a framework in which to dialogue with you about comments and changes and tinkerings we might need to do for whatever it is we're doing.

We are going to be tightening up on planning and a more coherent resource allocation.

Efficiency and morale is a major issue for us in this arena, and we're looking to make great strides there. We're actually having a lot of project officers and people who have been writing RFAs in the old way sort of like, "You mean I'm not going to have to do that anymore?" Yes, there's a different way you can do this, faster and so on.

And coming back to a bedrock issue, stability in SAMHSA operations and grant activities. So if you come to SAMHSA with a question, you will be coming to a place that is relatively stable and can dialogue with you constructively rather than, gee, we're not sure where we're going next year, or we're not sure where we're going this year.

I have to wrap up with this. You cannot be an agency head in this administration, you certainly cannot be an agency head in Secretary Thompson's "one HHS" and not have your eye on the President's management agenda all the time. I mentioned before, and it continues, we get a traffic light rating -- red, yellow or green -- every quarter on those five elements up there. The proposal that we have out now on the

standard mechanisms, as I look at it, it definitely relates to human capital, actually comes out of our capital plan but relates to our staff. It happens that we are using competitive sourcing, but that's not inherent in this.

Electronic government will be well positioned to go to standard announcements for the Department and the entire government. The OMB is actually working on one place for any grant across the entire government that you can get information. So we're positioning ourselves for this.

Lastly, budget and performance integration, because by linking where we're going to the budget, the planning, that's where we are.

These four announcements are out for public comment. Public comments are open until the 20th of October. We have an email address so people can send in comments by email, and we've gotten over 100 at this point generally along two lines: "This is great, we love the idea, anything you can do to make your lives simpler and our lives simpler, we're for it," and "Where will my grant fit?" So we wanted especially to be sure that all of our Council members were aware of this initiative, that if you have questions or comments or anything about it, to be sure that you let us know, me, Jennifer, Charlie, whoever.

We see this as a major advance. We have invested

a lot of energy in this and we are, I think, very pleased about where we are and a tad anxious about what we're going to be facing as we go along the line.

That is it. I will entertain any questions. But first I do need to hark back to an opening theme of the meeting. I want you to know that I am the third happiest man.

(Laughter.)

DR. SULLIVAN: Okay. Questions?

MS. SULLIVAN: Frank, it is very difficult for me -- and really, look at me right now as a preschooler, right? This is where I become so embarrassed, because when I look at what you all do on a daily basis -- I mean, there is not a journalist who could do any of this. So please look at me as Kindergarten 101.

Let us take a general approach. A person wants a government grant. This is just the most simplified question possible. There is an agency or a group that has a long history of great doings for great people. 101, all right? How do they get money? These are the basic kinds of who, what, when, where, and how questions that I get all the time, and I don't know how to answer it without getting into a maze. Do you know what I mean?

DR. SULLIVAN: Yes.

MS. SULLIVAN: So as far as the basic "how do you

get money" question, can you help me answer it? And please think of me as a cute six-year-old child with pigtails.

DR. SULLIVAN: This will definitely help, and your question prompts me to think that we need to boil some of this down into, as I'm sure we will ultimately be planning to do, a two-page fact sheet. You want a grant from SAMHSA? Here's what we're buying, the four mechanisms, and I'll call them blue, purple, gray and aqua. I don't want to use red, green or yellow, because those have vibes.

So we buy services. We will help you provide services. We will help you build your system with a single point of entry with a way to train your workforce staff to greet people when they come in the clinic. We will help you take something that looks promising and apply it in your own backyard, is the third one. The fourth one is if you have something you think is hot that ought to be considered for more serious evaluation, that's what we're doing.

So we are hoping that when this comes into play, that's what we're going to be saying. We're buying these four things, and this year we're buying it on the underage drinking population, the AIDS population --

MS. SULLIVAN: Can you say that a little bit closer to the microphone? I want to make sure it gets in the transcript.

DR. SULLIVAN: This year we aren't just buying, but we are buying in the area of AIDS, we are buying in the area of adolescent substance abuse treatment, we are buying in the area of reducing bullying. We're buying.

Another advantage to this approach, say we're buying reducing bullying. Well, in reducing bullying, we're specifically going to buy some intervention service capacity, and we're also going to buy some infrastructure capacity, or we're going to buy some number 2 and number 3. So we'll have the ability in this framework to take a more comprehensive approach. If we're going to make a major push -- I'll stick with bullying -- we're going to make a major push on bullying, I would hope you would see that SAMHSA is making a major push on bullying and they're buying infrastructure, they're buying services, they're looking at best practices. That way, we ourselves can know how it fits together. One of the centers might be doing this part, another that part, one branch this part.

I think this will be a big step in making it clear what it is SAMHSA is doing. The other thing I would say, and there's been a lot of references to CMS this morning, one of the things I learned when I was up there is that if it's not written down and it's not on a piece of paper or it's not in the system, it didn't happen. So you can provide the

best services in the world, and if there's not a paper record that you did it and put down the right billing code, you're not going to get reimbursed.

I say that because ultimately in the grant process, the people have to put their idea on a piece of paper, a disc, something where it can be evaluated and judged. I think a lot of times, a lot of applicants, especially new applicants, find that process daunting. It's like, "Why can't I just tell you what I want to do? Why can't I just show you that we've had a real good track record here and you have every reason to believe me? Give me a grant." You're going to have to make a formal proposal. It's going to have to be reviewed by peer reviewers and objective experts in the field. So that's something you should know when you go to the SAMHSA store.

MS. SULLIVAN: Can I ask you, have you ever come up with a group of people who you could refer those kind of people to as, you know, why don't you call so-and-so to help you on how to document yourself?

DR. SULLIVAN: We do a lot of technical assistance for applicants as to what we are about. We give workshops around the country. I think it would be worth taking a new look at that now that we're going to have a clearer picture of what it is we are doing. It should be

easier for us to communicate what it is we're doing.

MS. SULLIVAN: May I mention that there are a lot of wealthy backed groups that could afford hiring a consultant to get a government grant, but they would prefer to have SAMHSA refer a group of people who know, not a certification of such, but people who have been through the grant process. I know already, just in my limited picking up the phone, "Oh yes, she writes grants," and find out this person is filling in a blank.

So is there a certification process that people could come to, even in grant certification or referral for these small groups so that they can find someone to help them write grants or help them as the mediator between you, that they could take on, they could pay on their own to get the grant so it takes the burden off you, and you could have even a one-page referral of human beings that they could hire or someone in this middle process?

DR. SULLIVAN: That's something we could take a look at. I know that I would be concerned about recommending Rich Kopanda will be your man to write your grant, and if you get Rich Kopanda to write your grant, you're going to get a grant from SAMHSA. We'd have to find a way to get that information out there without endorsing or guaranteeing. But that's the kind of thing that is doable with the right kind

of --

MS. SULLIVAN: No, I'm talking about a CPA kind of registration. Do you know what I'm saying?

MR. CURIE: We have to always be careful assuring that there's a true competitive nature. There are a range of appropriate technical assistance ongoing workshops that are given to the broad public about educating folks. Also, I think individually there are those individuals who develop a reputation in the field of being competent grant-writers and they're engaged by a variety of organizations.

We'll always need to be very careful to assure the level playing field and non-biased competition. So we'd have to be very careful in any role that we would play, but we certainly have provided workshops, training, technical assistance to help a broad range of entities who have not applied for governmental funding before to learn the ropes.

MS. SULLIVAN: My specific case, Charlie, is that there are 483 charities in the Coachella Valley who are dying to get even a small, to them, government boost, while they would put in a 10-to-1 dollar. It is to them a small certification, and it is somewhat along the Bush endorsement of private funding along with public funding in a kind of co-dependency. You can call it that. But these kind of people always want someone who kind of, "Well, what is this and how

do we make this work?" They don't want to dip into the government maze without having some kind of understanding.

I have noticed that when the Bush administration does want, and I think we've talked about at meetings before where the Bush administration would like to have more of these private groups come in with funding on certain programs like this, and if we're going to have a little government help with some big private charities and things like that, sort of this coalescing of funding -- what do we call this?

MR. CURIE: Public/private partnerships.

MS. SULLIVAN: Thank you. Public/private partnerships. Thank you very much.

If that's going to happen, I think those kind of people often ask for somebody who has an understanding of this government grant process, and they're very frustrated in that. That seems to be the step that is missing to making that partnership continue.

DR. SULLIVAN: Lewis, did you have a question?

DR. GALLANT: Yes, I had a couple of comments. In terms of the development of the GFAs, is there any likelihood that you will be seeking input, guidance from the field in terms of what the need might be in terms of areas that you might end up developing a GFA around?

DR. SULLIVAN: I would say that we take the

information we have about the needs from the field and our communication with councils and a wide variety of groups. That's taken into account when we develop our proposal for the budget for a given year, and then once something makes it into that and clears the hurdles it needs to clear within SAMHSA and the Department and OMB, that is sort of the fundamental articulation of the major areas.

I think that is, as Charlie would say, the right thing or the thing we're going to do. How we're going to go about it I think is another area for dialogue, and that's where we would want to have as much of that how to go about it discussion up front, so that we're not looking at, yes, we're going to spend money on Topic X and we're not sure how we're going to do it.

So I think forums like this would be good for that.

DR. GALLANT: One of the things I would encourage you to consider as you look at the SAMHSA data strategy would be to look at the various data initiatives as possible vehicles by which you could draw from the need for certain kinds of targeting within state systems and make that more of a formal process. I think, Charlie, you said a couple of years ago that we're spending a lot of money on collecting data, but we don't do much with the data. So I think as we

evolve this data strategy, to let that drive, with input from the communities and from the localities, from the states, the kinds of things that you will eventually end up funding.

Secondly, I'd like to just comment that it's amazing to see that an idea can, in fact, cross two meetings. Generally, you hear an idea in one meeting and you don't hear it again.

DR. SULLIVAN: I will take that as a compliment.

(Laughter.)

DR. GALLANT: It is.

DR. SULLIVAN: I have a feeling that you are looking at the reason for that up on the screen. We are very much driven, and there is a lot of continuity in the President's management agenda. So sometimes good ideas don't get anywhere, and that's not a good thing. Sometimes bad ideas don't get anywhere, and that's a good thing. But right now, anything on the President's management agenda is moving somehow, and it's a very good thing.

Just one quick thing. We are on www.federalgrants.gov. That is where all federal agencies are migrating to put their announcements on there. We have been up on there since February. I'll be sure Toian puts this information in the next information packet to the Council members.

MR. CURIE: I might mention what we're passing around right now is relevant to Lewis' comments, the SAMHSA data strategy, which Stephenie Colston will be talking about later on, who is my special assistant for substance abuse issues. It gets right to the heart of what I think Lewis is discussing, that we need to streamline our efforts in gathering data. Data needs to be informing our budgetary decisions, which translates into what type of grants we would be inclined to offer, as well as consider. As Daryl was just mentioning to me too, that's also in our performance partnership grant process.

The short answer to your question is yes, Lewis, but those are the mechanisms for engaging that. So this is for your edification in preparation for Stephanie's presentation.

MS. SULLIVAN: Frank, thank you very much. I really, really appreciate it. For you to absolutely go through this maze -- and thank you for a new placemat, which colors do much better in my dining room.

(Laughter.)

MS. SULLIVAN: The rainbow placemat, Charlie, does much better in my dining room.

DR. SULLIVAN: I'm not sure that's a good thing.

MS. SULLIVAN: It will remind all my friends

every single day exactly how much work you all have done to clean up the mess, and I thank you all very, very much, because it really is remarkable.

DR. SULLIVAN: Thank you.

MR. CURIE: I appreciate you mentioning that too, Kathleen, because I can only heap praise on the group that did this. Some people said it could not be done. Frank hosted a celebration dinner at his house of the people from the various centers who were involved in this endeavor, and it was very gratifying for me to see the pride which every employee exhibited because of the result of this product. It's really, I think, a great example of what people can do when they transcend turf and they have their eye on an outcome which is going to be beneficial to all.

DR. SULLIVAN: Somehow I got myself in the position of if you get your proposal ready by February, I'll cook dinner for you. I think Gail Hutchings said let's add a little incentive to this operation. So that's what it was.

MS. KADE: Yes, please?

MS. DIETER: I just wanted to echo that, too. I think it's rare to see an evaluation or a new plan that actually is so open about the flaws you see within the system as it stands and going forward. I mean, it's just very impressive. We're very happy.

DR. SULLIVAN: Thank you. I just have to acknowledge, as Charlie did, that this represents the work of a lot of people in the agency who have kept their shoulder to the wheel for all the right reasons.

MS. KADE: Barbara, did you want to make a last comment?

MS. HUFF: I want to be just like those 100 people who have written an email. I want to ask a question.

DR. SULLIVAN: Okay.

MS. HUFF: I want to first say I really like this, because I think that's what everybody's first impression is, and I do. I want to congratulate you on your work.

I'm trying to figure out if family organizations were going to call our office and say what do you know about where family organizations and consumer organizations and technical assistance centers kind of fit in this, I'd be hard pressed to tell them exactly. So my sense is I'm going to be the one that gets that call, probably, and you also might get it by email. But I just want to be able to assure myself and others that they're not amongst the 15 percent that you're talking about that this won't fit for.

DR. SULLIVAN: No. One of the things that is in all of the announcements that are on the website is a clear articulation of eligibility, and not-for-profit and community-

based organizations are eligible to apply for all of these grants.

MS. HUFF: Okay. Can I get more specific? Can I be more specific? SAMHSA funds the statewide family networks, and there's 42 of them now, and they fund a technical assistance center associated with that, and they fund consumer organizations and technical assistance centers.

MR. CURIE: Part of the other discussion we haven't had today which we don't have time for is that there's this distinction, too, between grants and contracts.

DR. SULLIVAN: Right.

MR. CURIE: And some of what we talk about in the TA centers sometimes are contracts, and that's somewhat of a different process.

MS. HUFF: Okay. Well, I was thinking more about the cooperative agreement. We don't have that, so I'm not being self-centered around my question.

DR. SULLIVAN: I think for everyone who has this question, the first thing you should do is to look at what's covered in each of the mechanisms, and I think that when you look at the infrastructure one and the best practices one, all of the infrastructure, capacity building, information exchange, knowledge exchange is covered. So that's part of the flexible menu from which applicants can select.

MS. HUFF: That was the question. Thank you.

MS. KADE: Frank, relative to that question, could you explain how once these standard mechanisms are out, there will be notices of funding and you'll be able to clearly identify your program?

DR. SULLIVAN: Right. The four standard mechanisms are sort of the basis on which we will then target by short, brief, three pages or less, notices of funding availability, and it's in that that we would be much more specific with regard to this is geared towards consumer and families with whatever, this is geared towards treatment providers in high geographic concern areas. So it will be sort of a blending, and that way we'll have out there the market basket of what we buy, and then we will be able to figure out how we want to advance the different areas, like consumer and family, capacity.

MS. HUFF: That's good. Thank you.

MS. KADE: Thank you very much, Frank, and Jennifer for the good backup.

Since we're running late, what we will be doing is rescheduling the presentation on the mental health commission report for this afternoon, so we'll get back to you with a revised schedule. We wanted to make sure that we had enough time for public comments. So I would like to open the

session for public comment, and the first name on my list is John de Miranda, the National Association on Alcohol, Drugs and Disability.

MR. DE MIRANDA: Thank you. I'm here not to talk about what we do at the National Association on Alcohol, Drugs and Disability. I believe the last meeting we had a couple of people come from our board and talk to you about that, and there's some information out on the table in our newsletter if you're interested.

What I'm really here to talk about today is an emerging issue that I think is basically a threat to the alcohol, drug and mental health fields, and that is the case before the Supreme Court right now. The name of the case is Raytheon v. Hernandez, and let me preface with a few comments.

When I first got involved in the disability issue as a substance abuse professional, one of the leaders in that movement said to me, "You know, back in the early '70s, when we were working hard in the disability field to include alcohol and drugs as a disability, we didn't get a lot of support from you folks, but we felt it was the right thing to do, so we did it." She also went on to predict that our continuing disengagement with the broader disability community would be to our disadvantage. When the Americans with Disabilities Act was passed in 1990, as some of you may

recall, we lost some ground, we lost some protections for people with disabilities.

Similarly, the case before the Supreme Court now presents that same potentiality. We could lose big time, we could lose in a little way, or we can be reinforced by the decision of the court.

Very briefly, Mr. Hernandez was an employee at Hughes Aircraft in southern California. He tested positive for cocaine and was given the opportunity to resign, which he did. Three years later, after treatment and well into recovery, he presented himself for rehire, and the company, which at that point had been purchased by Raytheon, refused to hire him.

A lot of the case turns on the details and the procedure around that decision to not rehire, but Mr. Hernandez went forward and filed a lawsuit against Raytheon, claiming that his rights as a disabled person with addiction had been denied him. The initial court found for Raytheon in a summary judgment. Mr. Hernandez appealed the case to the 9th Circuit Court of Appeals in San Francisco, which reversed the judgment and found for Mr. Hernandez. Raytheon has appealed the case to the Supreme Court, and the Court has agreed to hear the case, which I think expresses some interest on the part of the Court to this whole issue of whether

someone with an addiction is disabled; and secondly, whether the rights and responsibilities of the employer trump disability status.

Oral arguments will be heard on October 8th, and I'm currently talking with a number of leaders in the alcohol, drug and disability communities about developing a communications campaign to express our concern about this case and to educate the alcohol, drug, mental health and disability fields about this case.

The worst-case scenario is that further restrictions come to bear on whether or not an addict or an alcoholic is disabled. It also has implications for other disabilities, including mental health and physical sensory developmental disabilities, and historically the Court has been narrowing the scope of the ADA. So there's quite a possibility that that might be the direction, although with this Court I think it's very hard to predict.

The Johnson Institute is in the process of working with us to develop a brochure that will communicate this issue to the field. Fortunately, we have a little bit of time even though the oral arguments will be heard on the 8th, and I plan to be there, and there may even be a press conference on the steps that morning. The decision will not be out until the spring, when the Court gets ready to suspend

for the year.

So the good news is that an amicus brief has been filed by the Betty Ford Center, by my organization and other organizations in the field, including the NAADAC organization that's represented here today, the state addiction systems that's represented here today. Unfortunately, the administration has chimed in on the side of Raytheon, and the Solicitor General has submitted a brief in support of Raytheon. So I want to bring this to your attention, encourage you either individually or organizationally to get engaged in this issue. I think it's a very important one. I believe that an article I wrote for Alcoholism and Drug Abuse Weekly has been distributed in your packets, I believe, and there are some outside there.

That's all I have to say about this. It's by way of briefing you. I would like to just also take the opportunity, since the RFA process is under redesign, I would use this as an opportunity to reiterate our request to Mr. Curie that was made some time ago to make sure that in the redesigned RFA, the Americans with Disabilities Act is listed as one of the certifications for contractors and grantees, which it is not as we speak. Some 13 years after the passage of the Americans with Disabilities Act, I think it's time for SAMHSA to include that as a certification since other federal

laws, such as the Clean Air Act, the Clean Water Act, the Drug-Free Workplace Act, are required certifications. It's really time to bring the ADA into that.

I'll end with that. Does anybody have any questions about the case?

(No response.)

MR. DE MIRANDA: Thank you.

MS. KADE: Thank you very much.

The next person on the list is Bill Northey of AAMFT.

DR. NORTHEY: Hi there. What I've asked to be handed out is a draft of our core competencies for the profession of marriage and family therapy. What we have done is convene a task force to look at, rather than focusing our education on standards --

MS. SULLIVAN: I'm sorry. Could you just repeat that? We had trouble hearing it. Go ahead, say it again.

DR. NORTHEY: Sure, core competencies for the profession. So what is the minimal standard of skills and knowledge that marriage and family therapists need to have in order to practice independently in both mental health and substance abuse agencies and settings.

We convened a task force of about 50 folks and asked them to generate ideas about what is it that MFTs know

how to do, and also what is it that they should know how to do. This is kind of the third iteration right now. It's got 136 competencies broken down into six domains, basically looking at how people enter treatment, what are the things they need to know about assessment and intervention, research, program evaluation, diagnosis and assessment, and it's now currently on our website. We're getting feedback from our general membership, and then the idea is that we will take these and use them to influence both the accreditation process. Forty-six states license marriage and family therapists right now, so it will go into how the licenses are issued, the exams that they have to take. We'll also look at training. Currently, training is standards oriented, so you have to have X number of courses, but it's not output oriented. It doesn't look at the skills and the knowledge that's obtained through that process.

So we wanted to share that with the Council. There's some background information in the cover letter. If you have any feedback, you can contact me about it. We're also going to convene an educator summit next July to take these, once they're finalized, which they should be by January, take those and say, okay, how does training need to change, what are the things that are currently being done well, what are curricula going to look like, what kinds of

textbooks, and things along those lines.

Thank you.

MS. KADE: Thank you very much.

The next person on my list is Frank Canizales from IHS.

I hope I pronounced your name correctly.

MR. CANIZALES: That's close enough. I always say it's like a can of olives, except it's Canizales.

I'm here on behalf of Dr. Grimm from Indian Health Service, who was invited to the meeting, and I'm very pleased to be here for probably the fourth National Advisory Council meeting. I just want to say that this is my fourth year of a detail from Indian Health Service that was asked by SAMHSA, going into the fourth year, for us to spend two days a week at SAMHSA, CSAT particularly, looking at the state block grants and linkage with American Indian and Alaska Native communities and issues.

I'd also like to take this opportunity to thank Mr. Curie specifically for his time and efforts and energy in traveling to Indian country and seeing some of the situations that we live under, which has just reiterated the critical importance of collaboration, which we started through SAMHSA's invitation four years ago.

We have had meetings with the state block grant

directors for the last three years. We started with the frontier states. We had about 10 frontier states at the first meeting in Coeur d'Alene, Idaho. That was with about 50 people there. We went to Chandler the following year. We had about 120 people. This last June, we had a national IHS/SAMHSA collaborative meeting in San Diego, California, and we had anticipated 150 participants. We had over 300. We've expanded the state directors' involvement. All 35 Indian reservation states nationally were invited, and we had 21 state directors that were able to attend, which we were very excited about.

For 2004, we have our hotel reserved for June 8th, 9th and 10th, again in San Diego, California. We're also expanding it to look at border issues. Canada has expressed a great deal of interest in participating and looking at border issues in Indian country and services that are utilized, along with Mexico. So we're very excited about the future and the continued growth and positive interaction between the state directors' block grants, both in treatment and prevention. This last year was the first time that prevention came into the venue, and we're just absolutely excited about that, and we're looking for continued expansion in that field.

I just wanted to say one last thing. I always say I'm a California Indian. I come from a small reservation

3,000 miles away, about 60 miles from Yosemite National Park. It's on 300 acres of land, and we have 100 acres that we live on. As I've said before, 200 of those acres are for our tribal chairman's seven cows. There are 48 voting members, tribal council members, of which I am one. Being here for four years in the D.C. area and working at a national level, I certainly have learned that cooperation and collaboration are so critical, and especially for our community based on our small budget in Indian Health Service and the extreme needs in our communities.

As your Household Survey just indicated, our adolescent youth in American Indian and Alaska Native populations is a little over 20 percent of our adolescents are in severe trouble. The point I want to make is are the things that you do here in D.C. translating out in Indian country? I can truly say yes, they are. Are they impactful? Yes, they are. Are they critical to our continued positive growth in health care issues? Absolutely.

I have in front of me a monthly newspaper that comes from my tribal council called Me-Wuk Country Today. I was looking at this month's publication, and you find out who is doing what, and it's a real positive spin on what's going on in the community and the different programs that are happening. I was reading through it and I got to the section

called Youth and Alcohol, and I thought gosh, this looks kind of familiar. So I read it and I'm looking in the back here, and here it is, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services.

Your voice is being heard in my little tiny community in California 3,000 miles away, on a tiny little reservation, and I thank all of you for your continued support and efforts that you do, because what you say and what you do does count. Thank you very much.

MS. KADE: Thank you very much.

Kathleen, did you want to say something?

MS. SULLIVAN: I just want you to know how touched I am by your comments in that I live on Agua Caliente land. For many people who don't know the "Land of Betty Ford," which everyone talks so often with, it's only a block away from Agua Caliente, and how many could I go on about? There's Morongo, and as we go down the tribal checkerboard of the desert, many people don't know that the Palm Springs land and Frank Sinatra is a block away from another Indian tribe. The Palm Springs land was checkerboarded with tribes.

So when I say I live on tribal land, I do. My community neighbors are my Native neighbors, and I do live and pay $900 a month to the Agua Caliente, and my band is owned by the Agua Caliente tribe. So may I just mention that for many

people who live back here, it may be an off name, Native Americans, but for many of us in the west, and for those of us who have just read the California budget and realize how much the Native Americans are contributing to next year's California budget, we do know through, their casino system, the importance of the Native American.

I as a Council member reviewed the stats that had been given last month, and I see the critical need to these people and how they are doubly affected -- that's the only way I can say it -- to the statistics, to the children and to the youth and through all the programs, and how I see the Native Americans do not feel welcome within the County system of Riverside, for whatever apparent reason.

May I just mention to all of you here that the Native American community is very deep in my heart, but they live in my home and my home is the reservation. So I want to thank all of you, too, and Charlie, for all the efforts you have made on the part of the Native Americans, as he so eloquently said. They have been truly hit by substance abuse and do need our attention. Thank you.

MS. KADE: Thank you very much.

We have time for more public comment. I would encourage people to come up to the mike, and if you could announce yourself and proceed. You can stand there or at the

table.

MR. RAY: Charles Ray with the National Council. I want to thank Charlie Curie and Betty Duke for pulling together around the primary care event. Every day I'm getting more calls from our state associations, from the primary care associations about requests for technical assistance, what are the best models and the best practices, and with Pablo's leadership in a number of areas, with Bob Glover's group, it really is important for the workforce and for the coordination of care to come together in support of the President's recommendations, 2.2 and 4.4.

We also are going to commit ourselves to the campaign for mental health transformation, and we believe that that is probably the most important vehicle to pull physical health, mental health and addictions together. Thank you for your leadership.

MS. KADE: Thank you.

DR. ZLOTNIK: Joan Zlotnik with the Institute for the Advancement of Social Work Research. I want to particularly comment on some of the discussions related to workforce that have occurred and the issues around the lack of training and competence and the workload and the salary issues. I think they're really critical. There's an article in the most recent issue of Youth Today about the salaries for

even service workers and how abominable they are.

So in looking at not just issues around evidence-based practice and curriculum development but really how you can sort of upgrade and attract a new cadre of people and the kind of leadership we have at the Council, and certainly at SAMHSA with Charlie and Jim Stone, I think is really important.

The other thing I really wanted to mention, it was sort of touched in brief, but around the collaboration between SAMHSA and HRSA and other federal partners. I think that's really critical, particularly when looking at workforce issues and how the Bureau of Health Professions and their efforts can link with what SAMHSA will be doing in terms of the transformation of the mental health system and fitting the workforce and the training pieces in that, and to make sure that as we're looking at mental health issues, that we make sure that the mental health needs of our older population are really paramount also in looking at the service delivery system, the family issues, and the co-occurring issues around depression and other things that people have so eloquently talked about from their personal experiences here, but real world in terms of looking at what are the health centers and the mental health centers and the mental health staff really need to be able to do. Thanks.

MS. KADE: Thank you.

MR. MOLLOY: Hi. I'm Paul Molloy with Oxford House. Two years ago tomorrow, Dr. Clark and Charlie Curie and I were having breakfast with Secretary Thompson in celebration of Recovery Month. A lot has happened since two years ago tomorrow, not the least of which is SAMHSA and everybody in government and out of government has sort of risen to the occasion and said how can we do our jobs better than we did before.

As we look at television and see the 26 million folks over in Iraq who haven't got the slightest idea of how democracy works, each of us began to think about what we'd taken for granted. It is that thinking about what we've taken for granted that gets us into new ways of trying to approach old problems.

A couple of weeks ago Ivette Torres and her Recovery Month group had a bunch of folks together who did various things in recovery around the country. Last weekend Ivette was down in Baton Rouge, Louisiana, where there were all kinds of groups in the State of Louisiana getting together celebrating recovery, how you deal with recovery, whether it's from alcoholism, drug addiction, or mental health. She ran into one fellow down there who is with Oxford House and starting to get 34 Oxford Houses going in Louisiana, and Marty

first came into Oxford House nine years ago, and he was 36 years old. He'd spent 17 of his 36 years in prison, not because of one term. He'd been convicted 31 times.

He'd come out, rob a Safeway or something else in order to get drugs. Marty's now got nine years in opening these Oxford Houses down in Louisiana. For those of you who don't know, Oxford Houses are rented houses. We own no property, have no money, have no assets. We just rent houses and put eight to twelve recovering people in it, of the same sex, and then they follow a standardized system of operation, and that standardized system of operation is democratic and based on the New England town meeting, part of our culture, part of something the Iraqis don't have the slightest notion about. But we elect officers and do that.

I started the first Oxford House back in 1975. In 1989, there were 18 of them. Government showed how it could act as a catalyst, because there was a small loan program to encourage states to do this, and we set up a little central office. Those 18 Oxford Houses have now grown to 987 Oxford Houses. In 1989, when we started that expansion, there were 200 people living in Oxford Houses. Today, there's 8,700 people living in Oxford Houses.

I mention this partly to push Oxford House, but partly to push the notion that the challenge of this

organization is to figure out how government can be a catalyst, to open the door so that American citizens can help themselves. Only in America would AA have started. Only in America would NA have started, or Oxford House, because part of the American culture is self-help, a free people getting together to help themselves.

I hate to quote de Tocqueville; everybody does. But in 1835, when he travelled across the country, he was fascinated by the uniqueness of America in that Americans voluntarily put things together. He said a tree might fall in Pennsylvania, Charlie, across a trail, and the neighbors just got together and chopped the tree away to open the trail again. He also mentioned that the Americans in 1835 had all kinds of voluntary associations to deal with intoxification and craziness. We're still in that same place, but I challenge you all to figure out how government can use a light touch in order to encourage everybody in America who has got something to offer, to offer it.

We're a smart, can-do people, and we need every smart, can-do person in this country to deal with the problems of alcoholism, drug addiction, and mental health, because they all involve behavior change. To get behavior change over the long term, it requires a changing in our culture so that folks figure out how folks like me, who was plain old drunk, doesn't

go back where he came from. Instead, he lives with some peers, gets some structure, gets excited about how you live life with comfortable sobriety.

Fifty-six percent of the folks in Oxford House are dually diagnosed, bipolar, schizophrenic. Fifty-eight percent have been homeless. The average length of homelessness, six months. Two Congresses ago, Senator Stevens said I'd like the Department of Defense to take a look at how Oxford House should fit in. He did it for two reasons. He wanted some Oxford Houses up in Alaska. I'm happy to say there are now seven Oxford Houses up in Anchorage. But I was shocked when I learned that the Department of Defense's approach to alcoholism, drug addiction and mental health had changed completely from what it was when I was familiar with it in the late '70s and the early '80s.

It used to be the model programs were in the Department of Defense. Somewhere along the way, we as a society shifted to this zero-based tolerance. If you've got a drunk or a druggie in the military, throw him out quick. Now I think the situation has changed again since 9/11. So the military can't afford that kind of philosophy. I'm in hopes that you will carry back to the DOD, gosh, we've got to look into this Oxford House thing. It's real cheap. They just rent houses. They live together. They throw people out if

they relapse.

NIAAA and NIDA have hired DePaul University to do some studies, and they say 80 percent stay clean and sober, which is fantastic.

So I've given you my propaganda speech, but I hope I've also given you a little bit of inspiration that as citizens in this country, we've got to set an example now for people all over the world. This damned democracy thing really works. Some of the exciting stuff that happens in Oxford House -- I should mention that we've been around now for 28 years. About half the folks in Oxford House are black, half are white, and we've never had a racial problem. We have 112 Native Americans, and we've never had an Indian war.

So I hope to keep up the good work. Push that Recovery Month notion. Figure out how to get the criminal justice system involved in these tables, because they're doing a lot of stuff. The Department of Labor motivates all these EAP folks. VA has a much larger budget than you have for alcoholism and drug addiction, and God knows how we tap into Medicare funds. Thanks.

MS. HUFF: Can I ask you a question? Do you serve adolescents?

MR. MOLLOY: Yes, at 17, 18. We also have 21 houses that are women with children, and we have four houses

that are men with children. They're very difficult, they're very hard to do, but I can say without qualification that we've had more success than any well-funded program anywhere in the country.

MS. HUFF: Does the same money serve adolescents, 17 or 18? Does it make any difference?

MR. MOLLOY: Everybody pays their own way. We don't ask for money.

MS. HUFF: Oh, I guess I should have asked you that.

MR. MOLLOY: You go get a job.

MS. HUFF: Are these kids in school, 17 and 18?

MR. MOLLOY: Yes. They work at McDonald's at night. If you've never worked before, the Department of Labor usually comes over and says what kind of job training programs do you guys have? There's a house at Northampton Street and Connecticut Avenue in the District that we always bring people out to show. It's a show house and has been there since 1976. The guys say we tell folks when they come in if the only job you've had is selling drugs and you dropped out of school in the 3rd grade or something, the way this thing works is we'll take you down to Magruder's, they'll give you a job. You've got to get up every morning when you're supposed to, show up on time, keep your mouth shut all day, do what the man tells

you, leave at the end of the day when the job is over, and they'll probably pay you at the end of the week.

People do that, and they do it over and over, and pretty soon they've caught that work ethic without drinking and without using drugs, and that works with adolescents, it works with folks who have got all kinds of other problems. If you're bipolar and you're living at Oxford House, your peers are going to say to you, "Take your lithium," or whatever other medicine you're supposed to take. If your behavior changes and you don't recognize it, the peers are going to say, "Have you seen your doctor recently? Something is happening."

Keep it simple. Rely on this whole notion in America that neighbors can get together and help themselves. Don't get bogged down with zoning laws. Just move into good houses in good neighborhoods and leave it to recovering lawyers around the country to bail you out.

(Laughter.)

(Applause.)

MS. KADE: Thank you very much.

MS. HUFF: I like that a lot.

MS. HOLMES: My name is Nancy Holmes. I'm with DB Consulting Group here in Silver Spring. We're a small business, a minority-owned business, and an SBA 8(a) firm.

We're also supporting your meeting today.

I just wanted to quickly address your comment about how does a community or faith-based group even begin to start to get through that maze. SAMHSA has done a very innovative and creative action about that in developing a curriculum on how to write federal grants. I was a part of that, but it was led by our Sandy Stevens, who is back here, with SAMHSA, so you can ask her more questions in detail about that.

But we took that curriculum all over the country, and it turned into a training of trainers project so that it could continue to have a ripple effect. What we found is that I can teach anybody the ABCs of how to put a grant together. It's motivating those groups that have creative, interesting ideas to work within their cultures, their communities, what they know works and how to shape that into what CSAP, CSAT, CMHS, wherever the grant origin is coming from and how they put that together.

That motivation part is the hard part, and that's what we have to keep working towards, to continue to help people understand that it's not just about writing it but it's about believing that you can win, and that is hard to convey. But when you were saying is there a group of people we can get, is there a group of grant writers or whatever, my

personal self-evaluation is when I leave that training, when I ask the question, "Do you want me to come here and write your grant?" they're supposed to say no, because they need to be able to convey what their program is doing in their own words, and in that process it helps them develop their projects and their ideas and their own infrastructure.

So that's what's important to me. The other little pitch I'd put is having also done peer review meetings and facilitating that process, that we need to do trainings with our peer reviewers. We need to see some different faces. We need to see some community and faith-based representation, more so than we do on our particular committees, so that the grantees that are submitting are feeling like there are people on those peer review committees that can hear them, understand them, and support their efforts.

It has been delightful to do that process, but the phone rings off the hook. We get many, many, many requests, even if SAMHSA and their funds can't pay for it. We get those requests over and over, help us, help us, we want to bring our ideas to SAMHSA. So, thank you.

MS. DIETER: So where does one seize grant-writing curriculums that SAMHSA has created?

MS. KADE: Actually, I was going to mention that we're going through the final editing stage and we're about to

publish the manual in the Federal Register. Toian, once that's done, we should alert the Council.

MS. DIETER: So it would be accessible over the website?

MS. KADE: Yes, that is correct.

MS. DIETER: And in the meantime, people who are interested in grants simply go to the website and look under grants and feel their way through that?

MS. KADE: At this point that is correct, although they do plan to schedule more training sessions. But the manual should be available publicly -- Sandy, how long do you think?

MS. STEPHENS: Actually, the participant manual is available on SAMHSA's website now.

MS. KADE: Okay.

MS. DIETER: So what do you look under?

MS. STEPHENS: We're still tweaking it, and it's not that easy to download, but it's also available in hard copy (inaudible).

MS. KADE: So we can get you that information from our SAMHSA website, we can provide you information to get it from the clearinghouse, and we'll let you know when it's on the Federal Register.

MS. DIETER: That would be great. You'll get

that to us?

MS. KADE: Sure.

MS. DIETER: That would be great. Thank you.

MS. HOLMES: And again, I would encourage that not only people learn that process, but that there's some interaction and working with trainers, with training of trainers, to help put that into the community for it to make sense, because it can still seem very daunting. Writing it was daunting. Reading it is daunting. So we want to make sure that's very user friendly. Sandy has done a wonderful job trying to make sure that happened. But the interactive exercises and the actual hands-on work you can do with people that are motivated to submit their ideas to you is really important.

MS. SULLIVAN: Thank you so much for appearing. The oddest thing is that I sat at a luncheon looking at 10 women. One woman was with $2.4 billion, and I didn't have an answer. That is my frustration. They have the motivation and the money. So if we all can get together with them, that's what I'm saying.

MS. HOLMES: That's very true, and again that's one of the pitches to try to find motivation for grantees that I use, that if you can write a federal grant, you can write any grant. It is time to tap into lots of other sources. But

again, the course that was created helps programs develop themselves, for them to identify all the factors that are going to be part of the evaluation criteria, but they end up, even if they don't win the first time or the second time or the seventh time, they end up with a stronger project and much more clarity in their own mission and their objectives.

MS. SULLIVAN: Great. Thank you. Thanks so much.

MS. KADE: Okay, thanks a lot.

MS. HUFF: What was your name again?

MS. HOLMES: Nancy Holmes. I'm with DB Consulting Group.

MS. SULLIVAN: Oh, we love you.

MS. HOLMES: Thank you very much. Me personally?

MS. SULLIVAN: We love all your people.

MS. HOLMES: Thank you. But actually, all that work -- you can go to Sandy Stephens here in SAMHSA and she can give you all that information.

MS. SULLIVAN: I should say to all of you in the public, the reason why I said that is because they make all our travel arrangements for all the people sitting here. That's why I mentioned that.

MS. KADE: We welcome more public comments. If we could limit the comments to about three minutes so that we

can proceed with the schedule, because we plan to reconvene at 1:15.

MS. RAAYMAKERS: Hi. My name is Marty Raaymakers, and I saw people doing the hungry shuffle, so I understand that. I'm the NAMI Consumer Council chair, and I would respectfully like to offer the assistance of the members of the NAMI Consumer Council. We look forward to regularly attending meetings like these, as well as consumer survivor subcommittee meetings.

The NAMI Consumer Council is excited and encouraged not only at the report of the New Freedom Commission, we're also excited by the changes that are taking place within SAMHSA. I'd like to say that we have representatives not only in every state but in the territories, and truthfully our consumer database is thousands. Normally, NAMI is considered a family organization. That's not necessarily true. The Consumer Council is trying to do intentional outreach to SAMHSA. We'd like to work with you.

MS. KADE: Thank you very much.

MR. SHAPIRO: Hi. I'm Howard Shapiro, executive director of State Associations of Addiction Services.

Charlie mentioned in his opening remarks that there is the possibility of an additional $200 million each

year for the next three years under the President's Access to Recovery proposal. What he did not mention is that this money is in jeopardy. It is very much in doubt at this point given different feelings in Congress and given the pressures on the Labor HHS appropriations bill. So he probably couldn't say this, but I think I can. Given this gathering of leaders of the field, I didn't want to let the opportunity pass to encourage each of the Council members in their own capacities as leaders of their organizations to contact members of Congress and to encourage my colleagues in the peanut gallery here to do the same.

Now is the time. This appropriations bill is on the Senate floor and is going to be going to conference soon. Charlie can't do this on his own. If the field doesn't speak up now, if the leadership doesn't push for that money now, in addition to promoting the block grant as -- and Charlie always says this -- the core infrastructure, then that opportunity is going to be lost, and it's $200 million and lots of treatment capacity slots. Thank you.

MS. KADE: Thank you very much.

MR. WHITEHEAD: Good morning. I'm Donald Whitehead, the executive director for the National Coalition for the Homeless. Four years ago, the advocacy community for homeless individuals, along with SAMHSA, created the grants

that benefit homeless individuals. I'd like to thank SAMHSA for that continued commitment towards one of the most vulnerable populations, a population that definitely negatively is affected by substance abuse and mental health issues, and I hope that the administration continues that commitment.

We do have a piece of the legislation that we helped draft very briefly, the Bringing America Home Act, which is a part of the Bringing America Home campaign that calls for an increase in appropriation levels for that program. So I hope that you'll support that piece of legislation and continue the commitment towards this very vulnerable population. Thanks.

MS. KADE: Thank you.

MR. HARLE: Hello. My name is Mike Harle. I'm the vice president of Therapeutic Communities of America. We're probably the largest user of the block grant for substance abuse, and I was asked by the membership to come here today to talk to you. I agree with Howard, we need all the resources we can get. The demand far outstrips the need.

A good example of that is I have a program in Baltimore. We have 60,000 addicts in Baltimore, and I opened the first program in 30 years that has been opened there for substance abuse. It's a pretty sad commentary on our society

that it's taken that long.

Three of the largest foundations in that community would like to open up another one and have actually found the land and have funded the development of a new institution. They're going to have to hold off for a couple of years, for 18 months at least, because there is no staff. We have a workforce crisis. If there's going to be any expansion of treatment, you're going to run quickly into a problem, and the problem is that in our field we don't use CAT scan machines. Our tools are the people, the human resources, and we have a crisis.

An example of that crisis is that 20 percent of my workforce -- I have about 800 employees. Twenty percent of them will either retire or be retired in the next five years. That's 20 percent of them. A large percentage of them, particularly people in recovery, have hepatitis C and probably in the near future will either be disabled or dead. So there are some real problems that have been there significantly. There's the aging of this workforce. I'm not going to harp on that because I think everyone already knows that.

The problem is that we need to be doing something about it, and what we feel is that there's a lot of discussion about this issue. The crisis has not turned into action, and we would like to help in any way we can to turn this into some

kind of action. Just a statistic you might want to keep your eye on. The National Survey on Drug Abuse and Health that was out on the table, if you look in that report, and you don't have to, the age group of 18- to 25-year-olds using cocaine is up significantly, heroin, prescription pain killers, ecstasy, and methamphetamines. So this covers the whole country. There's a significant increase.

Those folks haven't even showed up in treatment yet. Let me tell you what's happening here. That group hasn't shown up, and what's starting to happen is they're not being able to access and they're dying. I have pictures in my wallet of dead children, parents that I've dealt with who couldn't get their kids into treatment. Now, part of that has to do with private insurance not doing its load and pretty much, as I see it, killing kids. But even beyond that, it's now pushed all those children, young adults, into the drug and alcohol system.

We can't handle them, and then you're going to ask us to do three other things, work with people in the criminal justice system, work with people with severe and persistent mental illness, and provide training to people, cross-training, some significant training we need to do, on an average salary of $25,000 a year. I'm here to let you know -- I'm not here to blame you. It's no one's fault, but it is our

problem, and if we don't address it -- and I have some suggestions.

You have in your package a very brief letter. It's very brief. It's one page, one and a half pages. You don't have to use it as a placemat, and it has a couple of suggestions there. Loan repayments. Some of these things have already been done in other fields and they're easy to steal. We can steal stuff a lot easier than we can recreate them, and HRSA can probably help us with a lot of these issues. Scholarships, collaborative efforts with community colleges. It's something that's not taught in the community colleges and in state colleges. Public service announcements, career ladders, pathways for people in recovery to get into the field. That's where the passion is, and we've closed the doors.

One of the things we've done is we've raised the bar for people. But at the same time we were raising the bar, we were shutting the door, and pretty much we've shut the door to people in recovery, to minorities, to get in the door to do this kind of work. People aren't going to do this kind of work just because they look at a career chart and they say, you know, substance abuse treatment, and particularly when we're dealing with mental health, substance abuse, and a little homelessness, it's something I really aspire to do.

But there are people who have that passion, many of them in this room, and we've got to make those pathways for them to get into this field.

I know that you're hungry, but I want to let you know that this has got to be a priority, and if it's not, it's going to be a crisis. I'm here just to warn you. That's it. Thank you.

MS. KADE: Thank you very much.

We'll take one last comment.

MS. FORD-ROEGNER: I'll hurry.

MS. KADE: And I would remind you that we do have another comment session scheduled for later this afternoon.

MS. FORD-ROEGNER: I'm Pat Ford-Roegner, the executive director of the staff who staff all of these facilities, the counselors across this nation. I just want to reinforce what Howard Shapiro and others said about the leadership around this table in terms of getting in touch with your members of Congress and others, which we can certainly talk about.

We will be having our annual conference next week, Sunday through Wednesday. We encourage anyone who would like to be part of that in SAMHSA or CSAT or those who have scholarships for front-line counselors who are finding it much more difficult to get to annual meetings. We've started a

student committee to really reach out to people for the future. I unfortunately didn't get a chance to talk to Betty James when she was here, but certified substance abuse counselors are not covered by HRSA's loan repayment program. We have a bill pending with Senator Biden to address that issue and ask for your support on that.

We're very pleased that the Smithers Foundation has given us several scholarships that we will be handing out directly to counselors who are in school at the moment who hope to aspire to this profession.

So again, thank you, Charles, for your support and your leadership. We really do need to address the future workforce issues, and we will be continuing to be an advocate for that.

MS. KADE: Thank you very much.

We are scheduled to reconvene at 1:35, when we will have the presentation of the Mental Health Commission report, and then our schedule will be modified so that at 2:15 we'll be discussing the advances in medication, and then at 2:40 the strategic prevention framework.

So we'll see you at 1:35. Thank you.

(Whereupon, at 12:38 p.m., the meeting was recessed for lunch, to reconvene at 1:35 p.m.)

AFTERNOON SESSION (1:44 p.m.)

MS. KADE: Let's reconvene, and our next item is a summary of the recommendations from the Mental Health Commission report. Mr. Curie and Gail Hutchings will be doing the presentation.

MR. CURIE: Thank you, Daryl.

We do have a PowerPoint to go through today to present to the Council. Please excuse my back to the audience here.

The title of the President's New Freedom

Commission report is "Achieving the Promise," and the Commission, just in terms of reminding folks, was established on April 29th of 2002, where the President, in Albuquerque, announced the formation of the Commission, at the same time announcing his support for mental health parity, where he said, "Americans with mental illness deserve a health system that treats their illness with the same urgency as physical illness." I think you'll see where that sentence ends up actually being a theme throughout the report and its recommendations.

At that time he indicated that there must be three obstacles that we must overcome. One is the stigma around mental illness and the discrimination that takes place as a result of the stigma. Fragmentation, a fragmented mental health service delivery system. In fact, one could make an argument that there is no such thing as a mental health service delivery system. But clearly, the fragmentation of the different agencies that are involved make it very difficult to navigate. And again, unequal treatment and dollar limits for mental health care and private health insurance.

The President moved to address that second obstacle that was mentioned by forming the Mental Health Commission and again studying the problems and the current

fragmented service delivery system, to identify those problems and then make recommendations for immediate improvements.

The principles of the Commission that basically guided the Commission in its deliberations. One, looking and identifying positive individual outcomes guiding us. Secondly, the best use of community-based care. Thirdly, cost effectiveness and reducing barriers were also principles involved, recognizing we do have limited resources and we need to maximize and leverage our dollars. And moving best research to best practice, moving what we know works into what works, and looking at ways where we can support innovation, flexibility, accountability at all levels of government.

The charge and the goal of the Commission, which you can find in the Executive Order of the Commission, is "The Commission shall recommend improvements to enable adults with serious mental illness and children with severe emotional disturbance to live, work, learn and participate fully in their community." I think you see that idea of a life in the community for everyone comes through there quite strongly.

The members of the Commission, 15 appointed commissioners from the public and private sectors. We had representatives from state governments, from the judicial branch, mental health providers and advocates; we also had consumer representation. There is the list. One comment --

and I know Mike Hogan, the chairman, makes this comment often, and it's true -- they do not represent the usual suspects. We have a wide range of individuals who, many of them, have never necessarily been in a national leadership position around mental health, and we also think that that added to the depth and credibility of the Commission.

Ex officio members. These were members who were there by virtue of their office based on both the Executive Order as well as appointments by Secretary Thompson. As you can see, the Department of Health and Human Services, we did have CMS, Dennis Smith, the head of Medicaid, was the representative. Initially, Rueben King Shaw, who was deputy administrator for CMS, was the representative. In the National Institutes for Health, they designated the director of the National Institute for Mental Health to be the representative. That was Tom Insell. Myself from SAMHSA. The Department of Education, Robert Pasternak. From HUD we had Pat Carlisle, from Labor Chris Spears. I'm glad to see Larry here today. Fran Murphy from VA, who was just a tremendous -- between Larry and Fran, the VA participated quite fully in the Commission.

The subcommittees that the Commission was organized around. As you can see, I won't list each one. But you can see that the wide range of issues that are critical to

mental health service delivery were addressed. As a result of the subcommittee process, while they informed the goals and the recommendations, you will also be seeing over the next few months papers released which are not an official part of the Commission report, but the work of those subcommittees, for posterity's sake and for the record, will be available, which will give people, I think, a current scan of current thinking along those areas.

Each subcommittee, of course, analyzed a problem or program, identified the federal programs involved, considered policy options and recommendations.

Again, an interim report was required as part of the Executive Order. That was issued at about the end of October. The interim report was to give an update on the findings and barriers. As you can see, those are some of the major findings in the interim report, fragmentation being a major theme for both children and adults; high unemployment and disability, the disabling aspects of serious mental illness; older adults not receiving the care that they need; and mental health and suicide prevention not yet truly accepted as national priorities.

The final report gives us what I think is a clear vision for a transformed system, the principles that need to underline that transformation. Transformation is a word that

was consciously chosen. It was determined that fragmentation that we saw in the system, that the unacceptability of the status quo was such that it was going to take more than just tweaking a current system, more than just a reform. When you talk about reform, usually you talk about a one-time act of reforming something. Transformation talks about an ongoing process of a system that needs to be an evolving system, one that maintains a relevance over time. Again, as you look at the goals and recommendations and where we go from here, those goals that are stated truly reflect what we think a transformed system will look like.

Again, the Secretary supported this report. "Achieving the Promise: Transforming Mental Health Care in America" marks a significant milestone in our efforts to enable people with mental illness to live, work, learn and participate fully in their communities. The one thing I might mention about this -- of course, the Secretary commends the work of the commissioners and heartily endorses that we move ahead with an action agenda. The vision for that is articulated as a future in which everyone with mental illness will recover, can recover; mental illness can be prevented or cured and detected early; and everyone of all ages with a mental illness has access to effective treatment and supports that are essential for living, working, learning and

participating fully in the community.

Again, some of the underlying principles that the Commission reached consensus on, that services and treatments are consumer and family centered, not focused primarily on the demands of bureaucracies; that they provide real and meaningful choice of treatment and providers. You'll be seeing that care is then focused on promoting a consumer's ability to manage life's challenges successfully, facilitating recovery, building resilience, not just managing symptoms. In other words, people learn how to manage their lives instead of being managed by a system. People learn how to manage their illness. They learn how to manage their life.

These are the six overarching goals. Goal 1, Americans understand that mental health is essential to overall health, understanding that the link is inextricable and that we need to clearly understand that mental health should be on par with overall health. I will not be going over each recommendation in this particular presentation, but the recommendations get at such things as integration with primary care settings, that primary care settings and primary care providers need to have at their disposal and routinely do screenings around depression, routinely do screening around mental illnesses, serious emotional disturbances for children. Also, we talk here about a national awareness thrust, a range

of coordinated activities which communicate to the American public and to school children about debunking the myths around mental health, raising awareness around mental health, and also having a national strategy around suicide prevention in particular and bringing that into the mainstream.

Goal 2, a transformed system is one in which mental health care is consumer and family driven. "Driven" is a particular chosen phrase in that you'll also see the word "centered" used at times. But driven was particularly used throughout this because there's a difference between consumer and family centered care and consumer and family driven care. It's very important to be thinking in terms of consumers having a say in what their own treatment plan would be, having ownership of that plan, family members participating in that plan so that the recovery process is engaged by all the key individuals involved in a person's life.

"Driven" also indicates that consumers and family members should be at the public policy table at the federal level, the state level, the county level, helping shape public policy around mental health. We also know that we need to be aligning the federal programs to improve access and accountability to care, and that needs to be translated at the state and local levels as well.

Part of this also gets at the whole notion of a

system in which access to care opens up in the natural settings where people find themselves, that it's not a black box of where do I connect with the mental health system, but the mental health system is apparent in people's day-to-day lives.

One of the major concrete recommendations that will come out of that is a comprehensive state plan. To me, this is one of the most exciting and profound aspects of what I see coming out of an action agenda from this plan, and that is the idea that as we align the federal agencies -- and again, we got a great running start with the federal agencies that were ex officio members -- that we then work with our counterparts in the states, and we are working already in partnership with NASMHPD and NGA and NASADAD, to begin working with the notion of a comprehensive mental health plan that's not just coming out of the state mental health authorities. I think Pablo would agree, I know Jim would agree, and those of us who have been commissioners in a state would agree that a state mental health authority can only go so far with its own plan. It's not going to necessarily carry a lot of clout with the housing authorities, with the justice department, it's not going to carry a lot of clout with the education system, or even the drug and alcohol system if it's just coming out of the mental health authority.

But if it's a coordinated expectation out of the governor's office and you have CMS telling the state Medicaid authorities that they need to be participating and we're looking for this comprehensive plan, you have HUD, you have Labor, you have others from the federal level saying this is something that's expected, we could have one of the most profound changes in the world occur, that we have every agency engaged at the state level in a true mental health plan of that state which enlists those federal agencies that have some role in recovery, in assuring recovery.

Also, we would see a system where we fully integrate adults and children into their communities, as called for under Olmstead, basically a system that clearly does protect and enhance the rights of consumers. Also, we include in this, and I'd be remiss not to mention, ending such practices as seclusion and restraint in environments where, again, people can easily feel like they're being controlled and not learn how to control their own lives.

Goal 3, disparities in mental health services are eliminated. Again, this is consistent with the goal in the Department in disparity in health care in general, and that's assuring that our services are accessible by minorities, that they are culturally competent. Another way of describing it, the way I've described it, and I think it's consistent with

this, is that services become part of the fabric of neighborhoods and communities. We know what works, but that has to be part of a transformed system, that no matter what community you live in, no matter what your racial and ethnic background, no matter if you live in remote areas -- and we do focus in this goal on rural areas and geographic disparity as well. You don't have access to care, and we need to make it a priority and ways of concretely going about assuring access no matter where you live in this country.

Goal 4. To me, this is one of the critical goals, and that's early mental health screening, assessment, and referral to services are common practice. Promote the mental health of young children. Schools have to have access to mental health care, and access to care and assessment has to become part of school life for children. Preschool, primary care settings. When we talk about the integration with primary care and pediatric care, there are models that were described in the report, that there are instruments today so you can really go about doing that. But the ongoing training of primary care providers, and also school systems, to assure that assessment and services are readily available.

The other aspect to Goal 4, we did talk about co-occurring substance abuse and mental health disorders, recognizing that there is such a thing as a window of

opportunity during those teen years where we see individuals that begin using, and then abusing, and then becoming dependent on substances, and they really have had an emerging serious emotional disturbance and actual mental illness in their teen years that has gone undiagnosed. But if it was diagnosed early, screened early, you can reclaim -- well, you can more than reclaim. You can save years of a quality life in the future, and this Goal 4 recognizes that.

Goal 5, excellent mental health care is delivered and research is accelerated. Basically, the recommendation 1 under that specifically states accelerated research on recovery and resilience, recognizing recovery and resilience needs to be at the heart of the service delivery system, and ultimately to cure and prevent mental illness. In other words, we recognize at NIH that a quest for the cure is very much part of their vision, and we share that vision. Keep in mind that the Mental Health Commission was to focus on the mental health service delivery system, so not a lot of time was spent on the cure, but it was important to acknowledge that this is an important priority.

Recommendations around this include advancing evidence-based practices, finding ways to align financial resources and incentives, again identifying ongoing what we know works, and then having incentives aligned, training

aligned, ongoing in-service training aligned and academia aligned to ensure that we shorten that lag time of 15 to 20 years before research findings get translated into common practice, that we shorten that lag time. Also, expand and improve the workforce providing evidence-based mental health services, again through academia and in-service training.

We also need to develop a knowledge base in four under-studied areas, and those four areas that were mentioned in particular were to develop comprehensive minority mental health research programs; study the effects of long-term medication use -- we need a lot more study in that area and arena; examine the impact of trauma on mental health, particularly of women, children, and victims of violent crime and the role that plays in one's mental health and mental illness; and address the acute care issues for persons in crisis who need a safe and intensive treatment environment.

Goal 6. I think, again, this is a goal that I mentioned yesterday that you clearly see is part of health care transformation in general, that technology is used to access mental health care and information. I always add, and it's not stated, but to also improve quality as part of that goal as well, and that we use basically technology and telehealth to improve access and coordination. Part of the solution to the rural and remote area will be using that

arena. We're seeing today that technology is available in homes as never before. People can truly have a portal of entry to mental health assessment services and information, hopefully right in their homes if we use technology correctly.

Develop and implement, as I mentioned earlier this morning, the integrated electronic health record being a major recommendation here and needing to move ahead.

So in summary, the Commission proposes a combination of goals and recommendations that together represent a strong plan for action. No single goal or recommendation alone can achieve the needed changes. We need to keep in mind that also not one federal agency, no level or branch of government, no element of the private sector can accomplish the needed change on its own. Transformation also means we're all in this together. Collaboration between public and private sectors, among all levels of government, is critical, crucial. It's also critical or crucial that, again, we have consumers, families, providers, counties, states, federal officials all engaged, and academia all engaged in this.

Again, local innovations under the mantle of national leadership can lead the way for successful transformation throughout the country. So again, everyone has a role in that process.

So where do we go from here? Where we go is developing an action agenda. I'm pleased to say that SAMHSA has been given the lead and that basically it's our honor that the Secretary has asked us to undertake the first review and response to this report. What we are going to do and what we are doing already in this process is working at bringing together the federal agencies to begin to develop those relationships on an ongoing basis.

I have appointed, in developing a national action plan internally, while the Secretary and the White House have asked SAMHSA and myself to take the lead on behalf of the administration to operationalize this within SAMHSA, I've asked Kathryn Power, the director of the Center for Mental Health Services, to take the leadership of the SAMHSA team.

Those individuals on that core team will include Gail Hutchings, who will be my personal representative to that process on an ongoing basis. Stan Eichenauer, who is deputy executive director of the Mental Health Commission, is going to remain aboard as a project director. I saw Sybil here earlier. Sybil Goldman, our children's czar, will be on that overall governing committee as well. Also, Mark Weber is going to be part of that process, because we think communicating the action agenda and helping shape that is going to be important from the outset.

Again, we're looking to have a cross-cutting federal agency agenda that can better assist state governments. We want to make sure that the federal government is giving a consistent message to all state agencies, and that's going to take coordination, it's going to take ongoing work and effort to make sure that all state agencies are getting the same message around the mental health agenda.

Governors. Again, we're going to be relying heavily on governors' offices. We're going to be working with the NGA, because they have the authority and clout to bring all those agencies together.

Again, local agencies can adopt and adapt programs of excellence in their communities. One of the things we heard about consistently -- and those of us who have been providers know this is true, that many times you want to do the right things but the financial incentives aren't lined up to do the right things, or you can only bill for a particular kind of service. That's why it's going to be important for us to have ongoing connections with providers and payers, as well as the principles and the models that work to make sure that we align those incentives.

Policymakers and advocates hopefully can use the Commission's findings and recommendations to transform public policy. We're encouraging people to take this report right

now and not wait for there to be an overall action agenda. You can take what's in that report now and begin using it and help set the groundwork for change. Again, we're taking an inventory right now of everything we're working on and have been working on that's relevant to the recommendations of this report, and we're going to be putting that into the framework of that national action agenda. There's a review of that process that I mentioned earlier with the inventory, internal and external stakeholders working closely with our federal partners.

To learn more about the report and how you can help achieve its goals, there's the 1-800 number. Also, we still have a live mentalhealthcommission.gov online, and that can also be accessed through the SAMHSA website as well.

Any questions?

DR. HERNANDEZ: So do we expect the Matrix Reloaded, as you described it earlier, to be in line with --

MR. CURIE: Absolutely. In fact, I would say that if you take a look at the current matrix, let alone the new matrix, I think you can see a lot of fidelity between the matrix and the issues that have been highlighted in the report that we need to address. I think the Mental Health Commission report gives us a foundation like we have never had before. When I talked about stars being aligned earlier, we have a

Presidential Commission report now that, for the first time, formally embraces resilience, a prevention agenda, and early intervention agenda, and recovery as the framing for interventions and treatments and supports, and that's significant.

The good news is as we conduct the inventory of what we're already doing and how it fits within accomplishing a transformed system, a lot of groundwork and a lot of activity and a lot of progress is already being made. So hopefully, out of the chute, we're going to already show some progress and groundwork being laid with an action agenda. That action agenda will have a federal plan, of course, of how the federal agencies are aligning, but then the national action plan is going to be engaging state, local and everyone's involvement.

DR. HERNANDEZ: So then one could become delusional and think about the document we saw earlier, "Managing the Mission," the reengineering of the discretionary grants to be kind of a toolkit for us to be thinking about what will be forthcoming.

MR. CURIE: Absolutely. I mean, the discretionary grant process I think is set up now in such a way that you can use that as a tool, and use the Commission report as a way of filling in that structure.

DR. HERNANDEZ: Thank you.

MR. CURIE: Am I taking these questions, or Daryl? Okay.

Barbara?

MS. HUFF: You have all the subcommittee reports that I think are also going to be just a terrific advocacy tool. Are you going to publish those? I think you are, aren't you, going to publish those separately?

MR. CURIE: Yes, yes.

MS. HUFF: Okay. Do you have any timeline ideas on when those might be done?

MR. CURIE: It's imminent. Imminent in federal government means two years.

(Laughter.)

MR. CURIE: No, I would say we anticipate this fall. They should be out hopefully within two months.

MS. HUTCHINGS: I think we're going to need to make a decision as to whether we're going to roll them out individually. The children and family one is about 100 pages and needs to be edited, et cetera. So I think we're going to roll them out one by one, and given the two-column list of subcommittees, you can see that will be pretty daunting. But some are much more ready to go soon. So I think, starting in the next month or so, you'll see the beginnings of them come

out and get going. There's a tremendous amount in there.

MR. CURIE: I'd rather see them roll out separately because if we wait for them all to be done, it would take a while because they're at different points of development right now. I'd say in the next six to eight weeks, you'll start seeing some rollout.

MS. HUFF: Is the children's one kind of done, or is it one of them that needs more work? I'm just trying to think of a timeline. I'm trying to think of our conference, Charlie, and what we could have.

MS. GOLDMAN: I don't know what status it's in with the editor, but I think that the children's one was one of the, if I do say so myself, one of the better developed ones, but it may be too long.

MS. HUFF: I thought it was terrific.

MS. HUTCHINGS: We'll get back to you, Barbara, on this, particularly on that one.

MR. CURIE: The one thing I'll mention about the subcommittee reports is to keep in mind that the official report that the White House accepted is what's in now. That's what consensus was reached on by the whole Commission -- the goals of transformation, the 19 recommendations, and the body of what's in there. I think the key word here -- the subcommittee reports are there to inform the field, and I

think will be used as a very valuable reference for informing the field.

Lewis, and then Bert, and then Gwynn. Lewis, Bert, Gwynn.

DR. GALLANT: First of all, let me say I thought the Commission process was very thorough and very open to receiving information from a variety of stakeholders, including the substance abuse community, and I wanted to acknowledge that. The Commission invited the substance abuse committee to testify here in Washington and as it moved around the country.

One of the issues that we testified on was the issue of co-occurring mental illness and substance use disorders, and one of the things that we told the Commission that we were supportive of was the NASMHPD/NASADAD national dialogue on services for persons with co-occurring mental illness and substance use disorders.

However, I don't think the commissioners either understood or appreciated the amount of work and negotiation that went into the creation of that dialogue and the creation of the framework that underpins it. So I would ask that as the individual subcommittee reports are rolled out and used as working documents, that we attempt to reframe or at least incorporate the thinking that the two associations, along with

all the commissioners and substance abuse state directors who contributed to that process, put into trying to bridge this longstanding gulf that the two fields had and that the dialogue attempts to resolve, and ensure that that language and those methods that we put forward as a way of bridging that are, in fact, the basis from which we continue to move forward.

I think you all have endorsed the framework. It's in the report to Congress. You funded SASS and behavioral health councils to help with the implementation of the framework. So I would hope that all that work is not lost by virtue of a recommendation from the Commission that seems to talk about only integrated care.

I think as you are well aware, integrated care is one form of treatment that some folk require, but not all folk. If you have primary SA, you don't require necessarily integrated care. If you have primary MI, you don't necessarily require integrated care in terms of co-occurring integrated care. So I would just request that that be a consideration as you continue to fine-tune and release these reports in the future.

MR. CURIE: Yes, thank you, Lewis. The good news is the Commission report did endorse the co-occurring report to Congress, which does clearly describe the quadrants and

describe that approach. Also, the subcommittee report coming out will be a more detailed, in-depth document that will be getting at the matters you've just described as well.

I think the ongoing challenge will continue to be quantifying those quadrants more as the data come in. I think when we get to the point in the afternoon of talking about the Household Survey, I think we're beginning to see some things coming out of the Household Survey that can help us quantify that. Obviously, the Commission didn't have access to that at this point, and that's one thing that we need to continue to work on. But I think you'll find that there with that process, and we're going to continue to be working on the national summit on co-occurring.

Again, I mentioned the Johari window earlier. That's my shorthand way to talk about the quadrant that Lewis is talking about.

Thank you, Lewis.

Bert?

DR. PEPPER: I think that the opportunity for leadership that you have, Charlie, in terms of bringing forth concrete plans for implementation are more vital now than they would have been even 10 years ago, because just to place mental health and substance abuse prevention and treatment in context, we're much worse off now than we were 10 years ago in

the United States. We've lost a lot of money. Managed care has not been kind to mental health or substance abuse. Lengths of stay in acute psychiatric hospitals and in detoxes are abusively and criminally short in terms of clinical needs. Patients are being abused by three-day stays for major mental illness or serious states of intoxication, or toxic states. Residential care for substance abuse has been eliminated in place after place in the last decade. Psychiatric hospitals that were reputed to be the finest in the world are now places that just shuffle people around for a few days, then dump them out.

This is the actual context in which this Commission has been meeting and in which this Council sits and represents the interests of the country and calls upon you, with the mandate from the President and from Tommy Thompson, to bring this forward. We know that there will be no federal funds to implement any new programs other than the few that you've mentioned, because that's built into the mandate to the Commission. We know that the state budgets are being cut right now, particularly Medicaid, all across the country because of terrible shortfalls in state budgets.

We know that managed care has moved money out of mental health and substance abuse into other kinds of health care at the same time that I would say, if I were to

characterize what's happened to mental health and substance abuse care in the last decade in this country, I would say that the mantra would be "We know a lot more, we do a lot less." We know a lot more in terms of that we differentiated many kinds of disorders, many kinds of treatment. We have particularized in a very useful way scientifically. We know so much more, but we are so much worse off in terms of putting it into integrated practice, and I use "integration" in the broadest sense -- health and mental health, health and substance abuse, substance abuse and health.

We've atomized care as we've atomized knowledge, and that's not the goal. The goal of calculus is you take it apart so you know what the pieces are; put it back together. That, I think, represents a challenge to you and the staff here to go far beyond state and federal government, where the money is not available, to people who are going to pay, which is going to be private insurance and it's going to be foundation money and other non-governmental sources. The strongest way you're going to be able to get that kind of support is by public education. There's not a family in this country that, if they were educated, would fail to understand their personal stake in mental health and substance abuse prevention and treatment.

MR. CURIE: Thank you, Bert.

A couple of points. As Bert is referring to the money issue around the Executive Order, it was not that there would be no additional money added to the system. The notion was we needed as a commission to look at a mental health service delivery system and what elements and what model programs work with an idea toward gaining efficiencies, but the key there is if we could demonstrate what a transformed system would look like and should look like, it then puts us in a position to be able to use our current resources more wisely and justify resources in the future.

I know the President was not looking for a commission that would come in and say here's what we need to do and we could do all this only if you give us more money which tends to be kind of the way to approach things. It was looking for a more fundamental structural approach. Yes, we need to examine both the cross-systems agenda among the federal agencies to leverage resources and do it in the context of a recovery plan for individuals and then we also need to be looking at it in the context of the comprehensive state plan; in other words, pulling that together.

I would also mention that this gives us the opportunity also to put monies out for incentives, monies out for ways of approaching states and systems to perhaps use our dollars differently and use them better, but I think you well

stated the issues there.

Gwynn?

MS. DIETER: Yes, I first want to say I'm so impressed by this report. For me as a family member of a consumer who's been frustrated, saddened and desperate many times over the last several years in trying to access good care for that person, this report was unbelievable to me, that it actually stated and addressed things I had encountered on a personal level in many ways, and to me it just is a tremendous opportunity to make this transformation.

I agree with everything Bert said, and I guess the main question I have at this point in time is a couple of things. When this report was released in our newspapers at home in Colorado, there were a couple of articles on it. I didn't see anything much on the news, I could have missed it, and to pick up Bert's point, I really think the opportunity to finance and improve care as you do your report is only going to come if the public is made aware of what is going on and I don't think your average person knows unless they have an instance in their family.

I'm wondering if a national education initiative is part of it. I'm wondering how the media can be used or is used by SAMHSA in different initiatives that you have because I'm just uninformed, it's not that I haven't seen it, and I'm

really hoping that as you're doing your inventory and doing these different things that the education initiative can begin right away and whether more can be presented to the media so that the country becomes aware of this situation and then I think as you develop your guidelines, you will have a much greater chance of getting the funding.

MR. CURIE: You're exactly right, and in fact Mark Weber could speak to the media aspect probably far better than I can. The only way this is going to be done is through a multifaceted approach as well as public/private partnerships, and we do have Mr. Fuqua who appeared in front of the commission from Atlanta along with Tom Johnson and another individual, businessmen who have become very open about their depression. They put a million dollars on the table for a national awareness campaign. They're looking for us to help match that. We're looking to take advantage of that and work with them and it's going to take an ongoing relationship being developed with the media in order to have these issues highlighted.

There's already been groundwork laid on a national suicide prevention strategy which has not been rolled out yet but is looking to now being rolled out in the context of this Mental Health Commission Report and that multifaceted approach.

We also need to be looking at the curriculum in schools, in elementary schools, for example, in health classes, how's mental health being taught to our young people, how's substance abuse being taught to our young people, and getting it into the day-to-day cultural ground water. I mean, you learn a lot about personal hygiene as you're taking health classes in elementary school. To have a real focus on issues around how one feels and mental health and dealing with the stigma at an early age, again it's going to be multifaceted. So you're definitely, I think, articulating what needs to be involved in addressing especially that Goal Number 1 and that's exactly what you're getting at.

MS. DIETER: Right, and, for instance, I'm just sitting at home thinking pieces of the Drug Use and Health report, the charts that are in there, are very helpful, things like that. Singular items, can they be, for instance, delivered to every health teacher in the United States and perhaps three pages that are meant for parents if their children will take them home. I just keep thinking of sort of small things that could --

MR. CURIE: Absolutely. I think those are the exact types of things we should be looking at. Right now, we have the Reach Out Now Program that every year in the spring every fifth grade teacher receives. It's on underage drinking

and they have enough packets to send home with each child to their parents. So there's a classroom curriculum, there's that at-home curriculum for parents who want to reinforce that, and Scholastic is saying they're getting higher ratings than any other program they've done in terms of teachers using it and recalling their use of it and how it is actually overall implemented, and I think that offers us a model we can look at.

I also might mention that we do have in eight states right now and this is part of the inventory that will be included in the inventory, Center for Mental Health Services have the Eliminating Barriers Project which is addressing stigma and mental illness and mental health in a very direct way. I know that there's a proposal, I think, for $2 million for an antistigma campaign that Senator Domenici's supported that can be used in this national awareness and utilizing the media and others. So I think the ideas you have brought forth, we'd invite those ideas to be brought forward now as Kathryn's going through a process right now of collecting that inventory.

MS. DIETER: Yes, because now is the time, because the President supports it and we've got this report and that packet is fantastic, by the way, the Scholastic Magazine, and it's so usable. Anyway, thank you.

MR. CURIE: Daryl, how much time do we have left?

MS. KADE: I would give 5 or 10 minutes before we get too far behind.

MR. CURIE: Diane?

MS. HOLDER: I just wanted to ask a little bit more about the corporate potential relationships that SAMHSA may be able to develop. There was a survey done in Pittsburgh about two years ago of a lot of employers, small and medium and large-size businesses, and really trying to identify to what extent that understood the mental health benefits of their employees and whether or not they prioritized them in any meaningful way, and unfortunately, as in most surveys done with employers, their knowledge about mental health benefits, what their employees could or should have, and their ranking of how important it was was really very low, well below vision, dental, practically everything else.

So given that the corporate community is such an incredibly important group to sway, I didn't know if your one reference earlier to doing something with the million dollar matching was targeting corporations or whether there's something else going on or if we could have something going on.

MR. CURIE: No, absolutely. In fact, I think at the heart of this and the commission saw that the only way

we're going to move the agenda forward, it gets back to what Bert was saying, is if it's in the context of public and private. While our focus was on the public service delivery system primarily, it's hard to separate the two now, and when it comes to changing attitudes, we need to let people know that mental illness is a leading cause of disability and death in the world. The World Health Organization says that we need to tell that story. We need to get it out and I think we will have the opportunity and it only can be done in the context of public/private partnerships.

MS. KADE: I think we had one more question and then we could continue this in the roundtable tomorrow.

MR. CURIE: Okay, sure. So was Bert it or was someone else?

MS. HUFF: No, let Bert.

MR. CURIE: Are you sure, Barbara? You're deferring to Bert?

MS. HUFF: He's on my board.

MR. CURIE: Okay.

(Laughter.)

MR. CURIE: Okay, Bert.

DR. PEPPER: I just want to pick up on something you just said, Charlie. World Health Organization estimates that globally mental and nervous diseases represent 23 percent

of the global burden of disability and illness.

MS. SULLIVAN: I'm sorry. Can you repeat that, Bert, one more time? Do say it again one more time.

DR. PEPPER: Sure. Okay. I think everybody got it. My point is this, that I would like us to think about the subtle shift between antistigma campaigns which says be nice to other people and education which says we have met the problem and you are it. With 23 percent of the burden of all illness being mental and nervous, let's just bring that message home. What family needs to be told to be nice to other people when they could be told be nice to yourself and be nice to your kids and be nice to your mother and father? This is an at-home problem. I don't think we need to do antistigma. I think we need to do public education about what's going on in every American family.

MR. CURIE: I think that's wonderful, Bert, and when you talk about mental illness, mental disability being Number 1 burden, 23 percent, Number 2 is substance abuse, and so right here, we're dealing with the two leading causes of disability and of disease burden, and I think that that would be news to a lot of people. I mean, we far outrank even cancer and heart disease. Absolutely.

MS. DIETER: They just don't know.

MR. CURIE: Exactly.

Daryl?

MS. KADE: Thank you very much.

We're proceeding with our agenda and the next item is advances in medication-assisted treatment, to be presented by Dr. Clark.

DR. CLARK: It's my pleasure to be here this afternoon to talk about several SAMHSA projects that I'll discuss. One is the Screening and Brief Intervention Initiative and its role in increasing access to treatment and recovery, another is about information dissemination, outreach position training efforts as they relate to the new medication-assisted treatment delivery system, and then I want to mention something about the 14th annual observance of National Alcohol and Drug Addiction Recovery Month and community events in that area.

SAMHSA is continuing its use of the Targeted Capacity Expansion grant mechanism with a particular focus on what we call SBIRT or Screening, Brief Intervention, Referral, and Treatment Program to increase capacity and improve treatment systems by funding activities that lead to matching individuals in need with clinically appropriate treatment. By expanding the continuum of care available in communities, we expect to see increased access to treatment matched to a person's stage of illness and problem severity.

SBIRT is an agency priority targeted at the large number of people who are current drug users but whose drug use has not progressed to dependence, and one of the things that we believe, and as said earlier, intervention may help with the larger problem of access to treatment. From the public health perspective, there's a need to head off the destructive message which nondependent users send to others. We see nondependent users as an obvious reservoir of consumption that creates problems down the road.

Relatively asymptomatic casual users are likely to respond to brief interventions, ranging from highly structured five-minute talks to a half-dozen counseling sessions. Most can be effective in a doctor's office or within the hospital social service department or emergency room. While referral to treatment through assessment and treatment may be in order for some individuals, studies have shown that even brief interventions can be effective. Cost savings can be substantial when compared to the alternatives of detoxification followed by extended stay.

Accordingly, the SBIRT initiative, and SAMHSA has made a commitment of $22 million for cooperative agreements with states to enhance treatment and as many as seven awards ranging from $2.5 million to $3.5 million each will be supported for as long as five years, depending on the

availability of funds and the progress achieved. The agreements will provide services in general medical and other community settings, such as community health centers, school-based health clinics, student assistance programs, occupational health clinics, hospitals and emergency departments.

Applications are now in the process of review. They were received in early July and announcements will be made some time before the end of the month because that's the end of the fiscal year. So that's what has to happen, and we believe that the Screening Brief Intervention strategy, which is going to be administered through the states, will be an effective mechanism and will help to see these things put into effect.

In addition to our SBIRT strategy, I want to discuss with you the advent of office-based opioid treatment and what it means for SAMHSA. SAMHSA's been exerting its leadership to invite primary care practitioners to know that they should be part of the substance abuse treatment system. I think, as Bert's pointed out, we need a delivery system that is open at all ends and primary care practitioners could play a critical role.

Medication-assisted treatment, we believe, represents the face of the future. The last two decades of

substance use disorder treatments made it clear that opioid treatments can work, although we've lacked a medication strategy to approach that. What we've done is recognize that the primary care docs have been precluded from using opioids in the treatment of narcotic addiction, starting in 1919 with the legal case U.S. v. Webb. The Supreme Court essentially said treat an addict, go to jail, and in the classic reaction formation, physicians concluded all addicts were bad, didn't need to be treated, and didn't want to treat them.

As a result of the change in the law, primary care physicians will be able to treat people who are opioid-dependent with medication. We have a New Path to Recovery Project with a couple of physician-training opportunities that we're co-sponsoring so that we can change this. Congress, on October 17th, 2000, passed a Drug Addiction Treatment Act which allows doctors to prescribe certain narcotics, such as buprenorphine, for the treatment of opioid addiction.

Actually, the law said three, four, and five drugs approved by the FDA for the purpose of treating narcotic addiction. Well, it turns out there's only one drug and that's buprenorphine, and buprenorphine comes in two forms, Subutex, buprenorphine hydrochloride, and Suboxone, buprenorphine hydrochloride and naloxone hydrochloride. This is an alternative and these are in pill forms, so

practitioners can use that.

Senators Carl Levin, Orrin Hatch, and Joseph Biden have been particularly interested in this activity and their staff have been monitoring how we have been progressing. When used correctly under doctor's supervision, the benefits of buprenorphine, we hope, will be substantial.

The other thing that is quite clear when you get your Household Survey presentation, you'll see that there's been an increase in narcotic pain reliever misuse and buprenorphine will help practitioners address that. Narcotic pain medication emergency room visits rose 21 percent in 2002 from 2001, 119,185 mentions in 2002 over 99,000 in 2001, and that's a 45-percent rise from 2000.

The issue for us is making it clear that practitioners can do this and we are working with practitioners to gain access. We've trained doctors. We have a number of training sites.

The other issue with prescription drug abuse is that young adults and adolescents are using it. We've put together a SAMHSA/FDA collaboration targeted toward youth 14 to 25. It's public service announcements and pamphlets. It's called "The Buzz That Takes Your Breath Away." That's one material and the other one is called "It's To Die For," and a consumer education brochure entitled "The Buzz That Takes Your Breath Away Permanently."

The educational materials will hopefully continue to carry that message and I've been doing some interviews with mainstream media to address the issue of prescription drug abuse, particularly narcotic use. I was in Teen Vogue. So I was impressed by that. Teen Vogue did a thing on prescription drug abuse. It shows you there's this concern.

There's a tremendous increase in prescription drug abuse. It's as if the kids decided that prescription drugs were safer than street drugs and that's true, but they shouldn't be taking it unless it's prescribed. That's the other thing because we've got our problems with that.

We're also concerned about the twin epidemics of HIV/AIDS and hepatitis and injection drug use and the misuse of prescription medications because, as many of you are aware, with Oxycodone, you start off taking it orally and then you wind up shooting it up, and that's an issue.

In our collaboration with the FDA, our materials focus on the need to be knowledgeable about prescription medications, being aware of problems that may occur when multiple medications are taken, monitoring medications, and available treatment options. We're disseminating these medications-assisted treatment information and providing treatment guidelines to practitioners, working with the pain community because that's another place where medications are

complicated, and we work with the physician organizations.

So these two efforts with public information and buprenorphine overlap tremendously because the primary care docs historically don't want to acknowledge that they have a role. When I go to talk to primary care docs about buprenorphine, they don't treat heroin addicts, so they don't want to know about it. So I've now changed my strategy and I talk about prescription drug abuse. The pipeline for prescription drugs comes from the pharmaceutical companies, the manufacturers and distributors. I call them the four Ps, the pharmaceutical companies, the manufacturers and distributors, the physician, the pharmacies and the patients. Drugs have to come out of that pipeline and wherever they hemorrhage, whether it's at the pharmaceutical company, whether it's at the pharmacy, whether it's at the physician's prescription pad or it's the patient, that's how the drugs are getting into the pipeline.

So we want to make sure that there's medication-assisted treatment information. We want to make sure there are treatment guidelines. We want to make sure that there are public information campaigns to deal with prescription drug abuse, all of that is out there, so that we've got adequate training.

With regard to buprenorphine training, we've been

working with the professional groups, ASAM, AAAP, AOAA, American Psychiatric Association. We're also working with NAADAC, NASADAD, and the Federation of State Medical Boards to develop medical policies, and the pharmacy boards and the pharmacy trade organizations, so that we can get the pharmacy organizations involved in the issue of addiction.

Again, historically, despite the fact that all of these organizations, all these entities, with the exception of the nonmedical groups, their stock in trade is prescription drugs, they have never dealt with the addiction, except there's bad people out there and you don't want to have anything to do with them, but they were having a lot to do with them. So buprenorphine education forms address the issue of prescription drug abuse as well as physician involvement, nurses, pharmacists, and other people who are involved in that.

OBOT training cities include those cities up there. We've had trainings in all these cities and these are also community forum cities where we invite the community to come in. We talk about not just narcotic opioid addiction. We also talk about prescription drug issues and work with the local community, local media, to do these education forums, and the focus is pointing out the data, pointing out the experiences, getting people to talk about their experiences

with regard to prescription drugs and then addressing the issue of either opioid narcotic misprescriptions on the part of practitioners and then heroin, of course, which remains a drug of abuse in many communities. As some of you may be aware in some communities, it's prescription narcotics that is the dominant drug of abuse rather than heroin, and people want to say, well, it's the heroin addicts and we don't have to be involved, and that is not the case at all.

So we've had these trainings and community forums in all of those jurisdictions you see up there and we're also training physicians through the professional organizations. We anticipate 15 more community forums in other regions and we've sponsored over 30 medical trainings through the sponsoring organizations. We've trained nearly 3,000 physicians, in addition to the community activities working with the various groups. We use buprenorphine basically as the vehicle.

We're also using buprenorphine as a vehicle to work with HRSA. We've met with the director of the Bureau of Primary Care to address how we can get community health centers involved. We're using buprenorphine as a vehicle to deal with the HIV issue in terms of working with the Bureau of HIV, and so we hope this will help address this whole group of individuals who participate in the treatment of patients and

the treatment of pain and inadvertently or otherwise contribute to the problem.

I'd like to move to the next issue, which is Recovery Month. Our theme this year is "Join the Voices of Recovery: Celebrating Health." We've got more than 200 Recovery Month-related community events. I think that's about 240 now. Is that 240 now?

Ivette Torres, as someone mentioned earlier, has been working tirelessly on this effort and her staff and the contractors working with her, and we have only sponsored about 34 of these and I think that's the good part, is that the communities are adopting Recovery Month, and as was pointed out, we see our theme of "Celebrating Health" as not just applying to substance abuse but also to mental health because of the overlap in the co-occurring disorders.

The idea is to get communities actively involved in this month-long celebration, highlighting social benefits and the importance of effective alcohol and drug abuse treatment and prevention. Some communities have picnics, some communities have rallies, and some communities meet with legislature. I was in Salt Lake City and basically there were all these kids floating around -- I guess that figures for Salt Lake -- there were all these kids floating around. Obviously, some people don't know much about Salt Lake.

MS. SULLIVAN: I lived there for three years.

DR. CLARK: But it was really nice. I mean, there were all these kids floating around and they're from little kids, adolescents and people in recovery. We had a drug court judge. We had police there. We had bikers there. These were Bikers for Sobriety or something is what they called themselves. They all had Harley-Davidsons except for one guy had a Yamaha. He must have felt bad.

(Laughter.)

DR. CLARK: But the idea was to reach out to the community. That was a very good experience. Then L.A. and Detroit, and I leave here and go to Cleveland.

The idea is to get the communities involved and they are getting involved and Recovery Month has gone up and up and up and up, and you'll see the Household Survey apparently later, but when you look at the Household Survey, 19.5 million Americans, 8.3 percent of the population aged 12 and over, are using illicit drugs.

When the Household Survey was released, this was picked up. I was reading about the Household Survey data not only online and in the mainstream media but in the local press. So we're talking about this and that was one advantage of being out in the communities at the time just immediately after it was released. It was released on a Friday, and then

Saturday I was on the road. So I got to see discussion of it and there was fairly lengthy discussion in some of the media about the large number of people in America who are using illicit drugs.

Marijuana, of course, is a drug that is the most commonly used drug. We've got cocaine remaining as a problem with 2 million people. Hallucinogens, Ecstasy is being used now. More people have used Ecstasy than are using crack cocaine. Heroin use is being eclipsed by drugs like Ecstasy. We've got 6.2 million people or 2.6 percent of the population uses nonmedical uses of psychotherapeutic medications, including pain relievers, tranquilizers, stimulants and sedatives.

Again, these prescription drugs are something that we need to pay close attention to and we're working with FDA. We're also working with the DEA and medical groups on the humane and rational way to address these issues because we don't want, in our zeal to deal with drug abuse, to wind up creating a lot of pain and misery, and as I age, I don't want us to deal with pain and misery because we want rational therapeutic strategies, not strategies that will cause more harm than good. So we're working with these groups.

OxyContin, 1.9 million users who use the OxyContin nonmedically at least once in their lifetime.

Alcohol continues to be a widely used substance for the population, 120 million people, but the issue is we have 23 percent of the population who binge drink, and that's five or more drinks in a single occasion.

So from our point of view, when we present this data for Recovery Month, people are looking at, oh, okay, and people are concerned about underaged drinking. You look at you've got 29 percent of people aged 8 to 16 who are current alcohol users, 20 percent aged 15 current alcohol users, and of course, by the time you get to 21, 71 percent are current alcohol users. Of course, this peaks, but the issue is for those concerned about underaged drinking as a group, we have roughly 29 percent of people 12 to 20 who are not legal drinkers who are reporting alcohol consumption.

We also have almost 20 percent are binge drinkers and 2.3 million people who are heavy drinkers, heavy drinkers is five or more drinks at a single occasion five or more times in the past month. A key issue. We also have 1 in 7 Americans 12 or older who drove under the influence of alcohol at least once in the past 12 months.

So Recovery Month gets to make that pitch and we've got people who understand the complexity of substance use. Those in recovery certainly understand the complexity of substance use and are able to communicate that message.

Some of our Recovery Month objectives include the reduction of stigma associated with substance use disorder treatment and to empower individuals in recovery and those who are their family members, who are their family members in their community, to talk about recovery and to stress the importance of recovery and it's a wonderful opportunity. We also talk about prevention strategies as we are talking about treatment strategies. We see if we can avoid the complications of substance use. This partnership works where you've got this prevention treatment partnership.

So Beverly, you should feel proud that you can't be everywhere, but I'm helping to carry your message.

MS. DAVIS: I thank you.

(Laughter.)

DR. CLARK: I think this is one of the things that SAMHSA under Mr. Curie, what we're doing is carrying the message of the other centers, demonstrating that we're all in alignment with our vision, Mr. Curie's vision and the mission of SAMHSA, as you'll see in your material, making it clear that our investment in recovery is not restricted to substance abuse treatment alone but that while that's our principal focus, we recognize the overlap.

We've produced and distributed Recovery Month kits to various national and local organizations, federal,

state, local government agencies, officials, grantees, professional organizations. The kit is user-friendly. It's comprehensive. We're trying to assist the recipient groups to outreach to their local media to talk about recovery issues. There have been over 75 kits distributed, 10,000 commemorative posters, 10,000 flyers and brochures, 5,000 giveaways and interactive sites, and we're finding that groups bring their own materials to help talk about recovery and they link their activities with Recovery Month, which is what we want because we're looking for local activities.

I'm fond of talking about local control and sustainability, and if you can get the investment of the local community, you can sustain these issues and as the number of groups demonstrate, we're only sponsoring 34, but we've got over 240. The number of activities demonstrate that this is sort of a local awareness. Oh, yes, this is a wonderful thing that we need to be doing because this works for us. We have an interactive website also. We have a hotline that we use, a 1-800 number, and we also encourage people to focus on that.

Our website, www.recoverymonth.gov, which is very easy for people to remember, it's won five awards. It's had almost 4 million hits from January to August and a lot of hits don't prove that people are benefiting, but the fact is that we're seeing these things happen and that we're seeing large

numbers of people turn out. Depending on the community, you may have 50 people, you may have 500 people, and the idea is local control and sustainability.

Community events. This list is not exhaustive. This list just goes on and on and I think Ivette's group is doing a great job of recruiting new sites every year and promoting the notion of recovery and we have all these people. This map gives an example if you want to look at the map and we are working with different groups to think about what you can do and with the website, with the 800 number, with the materials, we are inducing people to say we, too, need to talk about recovery.

I've come up with, I think, a nice little catchy comment. Mike Ditka is going to be a spokesperson for the new Viagra clone or the Viagra next drug for penile dysfunction. So I point out that, gee, if Mike Ditka -- first, I ask the audience, anybody here know who Mike Ditka is? Everybody knows who Mike Ditka is. All the men do, all the older men especially. Football.

Well, if he can be the shill for penile erectile dysfunction and not have any problems with it, which I think is a good thing because men need to talk about male health issues, we should be able to talk about recovery without fear of stigma. The audience seems to respond to that because it

is a time that we need to move beyond being ashamed about being in recovery. Then if we can move beyond the shame of such issues as male sexual health, then certainly we should be able to talk about the importance of recovering from alcohol and drug abuse and that seems to work.

We have a radio tour with PSAs and I'm often called upon to do what I call mom and pop radio at some unusual hours, or we do small TV spots at some unusual hours. I did an interview at 11:30 at night. It only goes to 12:30 at night, but it's an important kind of thing in terms of recovery. So our television, we've got over $2.5 million in free air time. We've got free air time on radio with listener impressions. I mean, this is very important.

So we need to continue to address the lack of public understanding about the complexities of addiction and the numerous circumstances that keep those who are addicted in their own little nightmares. We need to educate others about the disease of addiction and present challenges similar to those. We focus on diabetics and hypertension, cancer, other conditions, and with our Recovery Month activity, we need to support those in recovery among their friends and families, community members. We need to talk about, as Bert points out, the whole integrated structure of our health care delivery system from primary care to mental health to substance abuse

and the various strategies.

As Mr. Curie is fond of pointing out, there are many pathways to recovery and we need to embrace those pathways. One shoe doesn't fit all. One solution doesn't fit all. But with a community that embraces various strategies for intervention, I think that we can facilitate the treatment and the celebration of health.

Recovery Month serves as a focus to energize people. We constantly remind people that even though it's September, recovery is a 365-day thing and it's not a one-month thing, and we just seize on September as a convenient focus to start the rest of the year off and we get organizations, employers, families and people to address the issue.

Celebration, the hope for recovery for many people, and so that's our issue and we always remind people about our website and our materials that they can access. We remind them about the cost of the materials. They're free. We remind them about our willingness to work with them so that they can address the issue of alcohol and drug abuse, mental health, substance abuse prevention as well as treatment.

That's CSAT's presentation.

MS. KADE: I think we have five minutes for questions.

DR. HERNANDEZ: Dr. Clark, will you make available those slides to members of the Council, please?

DR. CLARK: Oh, sure. We can make those available.

DR. HERNANDEZ: Thank you.

MS. HUFF: I can take the whole five minutes. In fact, I can probably take the next 25 minutes for questions. I'll try to be brief. I have several questions that I can also ask to you at another time.

Kathleen and I had to figure out over lunch how to change the world all in one hour, so we were a little late getting back, so I'm embarrassed to say that we probably missed the first five minutes or so. So this may be repetitive.

I don't know how to say this, other than just be blunt. Tell me about your commitment to children and adolescents. I mean in terms of treatment, because I saw up there and I kind of missed it because I was late, I saw up there schools and health clinics and school health clinics and I saw some of that up there on the screen, and I just apologize for having been late.

DR. CLARK: Well, this presentation focused on buprenorphine and Recovery Month.

MS. HUFF: Right.

DR. CLARK: But our commitment to children.

MS. HUFF: Yes, go ahead.

DR. CLARK: We have a commitment to children. It's not only in our priorities.

MS. HUFF: Right.

DR. CLARK: This morning, the reason I was late, I was talking with our Women and Children and Violence Co-Occurring Project, and when I came to CSAT several years ago, it was just the Women and Co-Occurring and Violence Project.

MS. HUFF: That's right.DR. CLARK: And they were up for refunding, and I said, "Well, what about the children?" They said, "Well, we hadn't planned to include children in the project." I said, "Well, you say you're up for refunding. What are you going to do about the children?"

MS. HUFF: I like that.

MR. CURIE: They said, "Well, we didn't plan to include children in the project." I said, "Well, that's all very well and good, but what about the children?"

MS. HUFF: Right.

DR. CLARK: So we found monies to include a children's subset in the Women and Co-Occurring. It's a priority for us. I've a task force led by Sharon Amatetti and working with others. We've got an adolescent initiative. So not only are we worried about -- we do treatment at CSAT but

working with the other centers.

MS. HUFF: We've got a lot of kids that need treatment.

DR. CLARK: Working with CSAP, our focus is prevention, early intervention and treatment. So that's not only Mr. Curie's priority, it's been our priority, my priority and my staff's priority.

MS. HUFF: Thank you. I appreciate it.

MS. SULLIVAN: It's very nice to meet you, Dr. Clark. First, I want to talk to you about Household Survey. The only time I ever as a journalist -- excuse me for doing this. I just realized I had this in my mouth. I've actually done that on television once. It was really embarrassing trying to get out on national television in the middle of a newscast, but I did.

The only time I've ever used the word "household survey" is when I talk about household cleaners, Ajax. So when the word "household survey" comes out, it sounds like to me the abuse of Ajax, Windex, and other household cleaners. Household Survey as a communicative technique is something I wonder about the pick-up on, and if you can address to us the pick-up of this study in the past month that it's been released and how often you have been asked in the past month since it's been released to be on cable shows and news shows

to address some of the stats and how the media has responded to what the Household Survey has presented.

DR. CLARK: Are they not going to have a formal presentation on the Household Survey?

MS. KADE: After we finish this segment and go through the Strategic Prevention Framework, we'll have a presentation on the Household Survey. Joe Gfroerer is here from OAS, and I think Mark Weber is here and so he can respond to some of those questions.

DR. CLARK: It's not that I'm trying to avoid your question. I think, though, what you should have is the more formal presentation and then we can talk about it.

MS. SULLIVAN: But Dr. Clark, only because of being in the media, I know that you're the guy I want on the air, I mean, in that you're the name that I want to book.

MS. HUFF: And I want you to talk about kids.

MS. SULLIVAN: So in that I know as a booker and when it comes to the Household Survey, I know Dr. Westley Clark is the one that everyone kind of wants. So I just wanted to know how many times that you were booked in the last -- were you called on a lot on this?

DR. CLARK: The Household Survey only got released five days ago.

MS. SULLIVAN: Oh, I thought it was longer ago.

It wasn't?

DR. CLARK: No, no.

MS. SULLIVAN: So it was just five days ago?

DR. CLARK: Yes, yes.

MS. SULLIVAN: All right. Okay. It just seemed like a long time.

DR. CLARK: Mr. Curie and Mr. Walters did a brilliant job of presenting the data and Joe gave very good technical backup and it was picked up by mainstream media and I think the way it was presented was well received. I mean, I saw it in the Salt Lake City Deserette News. So I think people will have questions now, but OAS also does, and Joe can spell that out.

MS. SULLIVAN: But just as a point man, you as a point man.

DR. CLARK: As one of the point people on this, OAS does many reports based on the Household Survey data and those things are also discussed over time. So we work collaboratively. I work with Mark Weber's shop and they kind of make the decision with Charlie who should pick up what. Depending on the type of the question being asked, if they ask about medical issues, obviously, based on my background, I'm generally the person that is turned to.

But I think the media has responded, at least

from what I saw and I haven't done a comprehensive overview of the media, that's Mark's shop, but the stuff that I saw was very, very impressive, and I was surprised. I mean, it was a Saturday, and I'm reading about the Household Survey, both online and in the local media. So they thought it was important enough to put it in the paper.

MS. SULLIVAN: Yes, but Dr. Clark, if I had my way, it'd be leading the evening news on every network and with news bulletins. So my perspective is a little different. Thank you.

MS. KADE: Thank you. Obviously, Joe is here and Mark is here and we'll try and address some of your specific questions at that session.

If there aren't any other questions, just to keep on schedule, I'd like to move to Beverly Watts Davis to give us a presentation on the Strategic Prevention Framework.

MS. DAVIS: Council members, I am truly pleased and honored to be here. I do regard to all the true heroes and sheroes who are out here and I truly thank you for your time, and what we're going to be sharing with you all today is part of what we've done at CSAP since I guess I'm now about 120 days old, but truly it's been a wonderful adventure.

Having said that, I wanted to be able to just begin to really talk about the CSAP vision and realization of

the SAMHSA mission, and before I get started, what I'd like to be able to do, because no person truly is successful by themselves, I would just like to very quickly recognize the CSAP team.

Would those from CSAP please stand up? Very good. There are many that are here and please give them a hand because they are truly part of my A Team.

(Applause.)

MS. DAVIS: I do want to recognize two branch chiefs, Soledad Sambrano and Rose Kittrell. Would you all please stand just very quickly? And my new special assistant, Ms. Debbie Costell. Stand. We certainly want to recognize Elaine Parry, who is certainly our deputy director. Elaine? There she is. She's a little bitty girl.

As we look at SAMHSA's Strategic Plan and the vision, we look at the whole vision of a life in the community for everyone. The prevention part of this is the building resiliency and the treatment part of that is facilitating recovery, but as we look at the phrase "a life in the community for everyone," when we talk about prevention, we talk about a quality life. We know people have a life in the community, but the resiliency piece of that is the prevention, and as we look at prevention, our goal is to create that strategic infrastructure, that when you think about

resiliency, you think about bouncing back, things that bounce forward, bounce up, that you can bounce back, and the things that we put in place are going to allow our communities to not only to bounce back whether or not if they've unfortunately been affected by the disease of addiction, but also to think about being resilient as they go forward in life, to make sure that they are strong, that we are helping to build healthy and safe communities, and in doing that, as we look at fulfilling our mission, there are three things that we are going to be stressing and that is accountability, capacity and effectiveness.

Coming from the private sector, we have a phrase that we use and that's called "spiritreneurs." That is, being entrepreneurial in promoting innovation and efficiency but combined with the whole spirit of service and recognizing that everything we do here at the federal government matters to someone in the community, everything we do, and to that end, since we look at the federal government, we have to recognize the federal government in and of itself does not quite frankly do any direct services. We don't deliver the services directly, so it's really incumbent upon us to be very good partners.

So in terms of being good partners, what we want to be able to help our primary constituents, those being

states and communities, is to do these three things well. That is to be accountable in what it is that they do and that is, in terms of being accountable, we want to help our states to track national trends because it is so very difficult to stand before Congress and not be able to show outcomes. As we look at accountability, we recognize that we have to develop new tools, new tools in the field of prevention that truly capture the critical mass of things that we do, because it's very difficult to show the effectiveness of something that you've actually helped prevent from happening.

To that end, we're going to be looking at establishing both core measures and different tools for reporting outcomes, and to actually promote some uniformity, it will be wonderful, and I know you all can relate to this, for us as we look across the prevention field, that when we look at all the people who are in the federal government who are doing prevention work, whether it be Education, Labor, Justice, or HHS, that we actually have some core measures that we can all measure because in communities, as we know, there is not usually one person doing prevention, just as when people come to you with a drug problem, it's not the only thing they have. No one comes to you with just a drug problem.

We need to be able to show the connections and

how we leverage prevention and that prevention is in fact that thread that runs through as we look at prevention, intervention, treatment and back around and how we promote resiliency. As we look at helping our states and communities be more accountable, we have to be able to build our capacity to in fact do that.

Because we have a little bit more money than states, it's going to be incumbent upon us to help increase their capacity to measure what it is that they do. As we go forward in this presentation, you will see the other tools that we're going to be putting on the Internet, so that people can actually have web-based accountability systems that will help to generate common core measures that can then help us be able to frame the national picture and show that prevention is in fact working.

The effectiveness, as we look at the third leg of this mission, is how do we help people be effective at what it is that we do. We know in our field, people work very, very hard, but we want to be able to help them not work harder but smarter, and in order to do that, we have a way to be able to now say, through many of the science-to-service initiatives, we know what works. The key is going to be how do we make sure that when we import that into communities, that they are taking a look at have they done the appropriate needs

assessments, so we know that they're hitting the target? Do they in fact have the capacity to in fact do what it is that they need to do?

When we look at the effective programs that are out there, oftentimes many of the effective programs as they were being developed might have cost a half a million dollars to actually implement, but when communities actually write grants, oftentimes they're going to write a grant for $150,000 or $200,000. Nine times out of 10, if they write a grant for that, it is going to be highly unlikely they're going to be able to implement a $500,000 program.

So it's important for us to match up capacity with in fact the programs that are out there that meet the need so they can in fact get outcomes, and so what we are doing as we work through our communities and our states is helping them understand here's what the capacity is, here's what we're doing in terms of implementation. We've done the correct needs assessment. Here's how we implement effectively and this will help us get outcomes. So we don't have people, quite frankly, reaching farther than they can because if in fact they do that, then they for sure will not demonstrate outcomes and that has been a real problem for us in the field.

When we look at the prevention framework, we must recognize that there are some basic principles that follow

that. Number 1, as I talked about, since the federal government itself does not actually deliver services, we do have to rely on others, but we do now know, from the many years that this field has been around, that we now know a lot about risk and protective factors and we know that if in fact we can reduce the risk factors and increase the protective factors, then we in fact are going to be able to see reductions in substance abuse and different choices made by our young people.

We recognize we cannot do this work alone. We have to be able to look at public and private partnerships. It is impossible to actually, quite frankly, get the kind of outcomes we want by doing this by ourselves because in fact this issue is way too comprehensive and has so many different sides to it and so many aspects of it, that if we do not use prevention as the dot connector, so we can connect the dots, we will not get the kind of results that we need.

That follows to the next point, that we have to be comprehensive. In being comprehensive, this does mean that when we look across the country, we must make sure that we are tieing into different opportunities.

What you all are now looking at right now is one of our flagship problems and that is the State Incentive Grants. True to the vision and the directives of Mr. Curie at

CSAP, instead of doing a whole lot of things, putting lots of money out there and hoping that people will apply for different things, what we're going to focus in on are a few things that we do really well, one of those being the State Incentive Grants and how we actually relate with states.

With the states, we actually have three types of funding that actually come from CSAP. Number 1 happens to be the block grants which Dr. Clark talked about, and there is 20 percent of the block grant that is actually set aside for prevention, but in addition to that, we also have what is also called State Incentive Grants and this is what will be our true mechanism for making sure that we are actually building a state prevention infrastructure throughout this country. By 2004, every single state will have a State Incentive Grant.

What's really important about this is the fact that by having a State Incentive Grant that goes into states, it keeps SAMHSA and prevention on the radar screen of policymakers. Secondly, what it also does is it makes sure that we have a dedicated amount of money that actually begins to look at creating a state prevention system. The SIGs, the State Incentive Grants, will be our mechanisms for when we begin to want to address different issues, whether it be underage drinking, so that we have a mechanism within states that we're actually able to funnel the dollars into so that we

can actually begin to target specific areas throughout states to really address the needs that are out there.

When you see the State Incentive Grants, all the dots represent all the subrecipients who are actually receiving dollars from these State Incentive Grants. These dollars go into the governor's office, who oftentimes may give them to the single-state agency or some governors actually keep these dollars and actually funnel money through the actual governor's office, but what these dots represent, these are all of the organizations who actually applied for funding and actually received funding and are now actually delivering prevention in their communities.

The next slide that you will see also represents other grants that are what we call discretionary grants. These are the grants that, through particularly by following congressional intent mandate, hearing the needs of the field, following trends, we are actually providing grants to, for instance, specifically address Ecstasy or methamphetamine or particular high-risk youth grants or fetal alcohol syndrome, or these are discretionary grants in which a community has actually presented and made their case for what's called a community-initiated grant, where they have identified through a comprehensive needs assessment a need that they have and through these grants were able to actually address those

needs.

I just have to say as we looked at many of the model program things that have come forth over the years, it has really been through many of these grants that we have actually had our model programs. The innovation comes from the field. As we look at model programs, things are generated from the community up, and with the grants that CSAP has been put out through these grants, that is how we actually got our original model programs that focused in on high-risk youth. Many of these grantees and people like them actually developed these protocols early on as we were looking at how do we address risky behavior, how do we take a look at protective factors. Many of the environmental programs were focused on this and they came through the discretionary grants and CSAP's programs.

When I talked about the redwoods that we are going to be focusing on, there's one of the other things that we will be doing well, and that is looking at training and technical assistance capacity. CSAP has what is called Centers for the Application of Prevention Technology, affectionately known as our CAPTs. We have five of these CAPTs and we have had one specialized border CAPT, but what the CAPTs primarily do is they provide actual training and technical assistance, and earlier, I think, Gwynn, was it you

who was talking about possibly training technicians in grant writing or was it Barbara? No?

MS. DIETER: Kathleen.

MS. DAVIS: It was Kathleen. I'm sorry. One of the things that we found is that the same questions you ask are asked all the time, Kathleen. How do I get a grant? How to begin to couple with people?

What we found in working with the CAPTs is oftentimes when we put out dollars, there's usually training that accompanies it, but we have oftentimes asked people from communities that come to Washington and be trained, et cetera. Well, when we do that, it really limits the ability and the capacity of organizations to quite frankly send the number of people they really need to send and actually to make organizational changes. It's very expensive to come here and oftentimes organizations, even though they got a grant, they can only send usually one or two people to come here for training or technical assistance, and you all know from your organizations, when one person comes, they get a lot of information, but when they go back home, it's one person who's actually trying to make organizational change.

So what we recognized, too, is that if in fact we drive the training closer to home, closer to where our communities or closer to where our constituents are, we have a

much better chance of reaching a larger and critical mass of people because, quite frankly, they can do what we used to do. We can rent a van for $59 and we can put 15 people in that van and we can go to a training and that enables us to actually get the kind of information and the type of training that we need out to people in much larger numbers.

When we heard from the rural communities, they use the CAPTs, I mean, just voluminously because they're in rural America. The ability for them to actually amass enough dollars to be able to come here and to stay on top of things is not as great as possibly as some of the larger urban centers. So in the rural areas, we have a rural initiative in which we're partnering with what's called the area health consortiums and we'll be partnering with them, so that our CAPTs will actually be conducting all types of educational materials, summits, conferences, et cetera, because they have the resources and with that kind of training available, you're able to get people from rural areas, from inner cities, et cetera, coming together.

The good thing is not that they just access training, but you know what they also access, they access each other, because you learn more from each other and sometimes out in the hallway talking than you do sometimes sitting in a training because someone will talk about the one problem that

you have. So it is about bringing the services to our customers and how do we reach them, so that we can be able to meet that need? You can see that our CAPTs are greatly utilized because, as you see, we provided over 20,000 hours of TA and training in 2002.

MS. HUFF: Where are they, Beverly?

MS. DAVIS: Our CAPTs? Let me tell you where they are located. Thank you, Barbara. The Western CAPT is located in California. The Southwest CAPT is located in Oklahoma. The Northeast CAPT is located in New England. The Central CAPT is located in Minnesota. The Southeast CAPT is located in Mississippi.

So again, they have the regions within the country and the good thing with these is that I'm hoping that as we move forward, Dr. Clark and I will utilize our CAPTs along with what's called the Addiction Technology Training Centers to really combine, so that we truly have that one SAMHSA message coming out that we will do training and TA in a seamless type of training.

The other tools that we have, some of you may or may not be familiar with what's called NCADI. That is the National Clearinghouse on Alcohol and Drug Information. NCADI is truly this nation's one-stop resource center for the most current and comprehensive information about substance abuse.

What's so important about this center is that anybody in the country can actually access it. You don't have to be a provider, you don't have to be a grantee, but that you can be a parent and want to get information for your child, you can be a PTA member, a church member, et cetera, but you can actually call and they will be sending you information.

I remember in the field, I used to call and order pallets of information and they would actually send me pallets. We would actually take trucks and go pick up our pallets of information and distribute thousands and thousands of pieces of literature across our community.

This resource is just a tremendous resource. It is also a resource we use for telecasts and broadcasts. The Recovery Month items that were done by Ivette Torres were actually done through here.

We also have what's called PREVLINE. PREVLINE, standing for Prevention Line, is a web-based resource and that also, too, is a place for those who don't want to access NCADI or actually in addition to NCADI will access information through PREVLINE. You can go right on the web, pull down information.

The one good thing about the government in terms of materials we produce, it is in the public domain. So oftentimes when you want to get a message out, you know you've

got core information but you want to customize it to your community, you go on PREVLINE, you pull down the information, you put on your logos -- yes, you actually can, Gwynneth, you can do that -- put your logos on it, do those other kinds of things. You must always keep at the very bottom "SAMHSA product."

(Laughter.)

MS. DAVIS: But you can get those out and you must keep our tagline, but you can put anything on it and you can customize it and get this out so the community begins to own those pieces of information. They're yours.

MS. SULLIVAN: Did you just do this?

MS. DAVIS: Yes.

MS. SULLIVAN: Where did you do this?

MS. DAVIS: PREVLINE?

MS. SULLIVAN: Yes.

MS. DAVIS: PREVLINE's been around for awhile, which also tells you we've got to do a much better job of making sure people know about it.

MS. HUFF: I didn't know about it either.

MS. DAVIS: PREVLINE's there for you. In addition to that, we have RADAR centers. RADAR centers. Actually, Barbara, this is something you want to think about. Being a RADAR center is actually an extension of the National

Clearinghouse because with a RADAR center, you actually are sent information materials so that you actually become a small hub, a small information center for your community.

We have 714 of those. We're going to be working with many of the tribal colleges, the historically black colleges, Hispanic-serving institutes, and they will also become RADARs so that we can make sure that on those campuses, we're getting out this kind of information and you all, this is for today and today only -- Barbara, Kathleen, Gwynneth, Theresa, today and today only -- we will make you a special and you, too, can be a RADAR center.

MS. HUFF: I want to be one.

MS. DAVIS: That's right. Joel. But actually you are. It truly is a form, and what's really important about this and this is what prevention is about, it is about promoting resiliency. It is about connecting. It's about making sure that we have connected so that we can all help each other and that truly to become a RADAR, you only have to fill out a form and you can actually become a RADAR, so you can distribute these in your communities as well.

MS. SULLIVAN: Can a kid be a RADAR center?

MS. DAVIS: A RADAR is actually limited to organizations.

MS. SULLIVAN: All right.

MS. DAVIS: But I will tell you this, if young people want to get together and actually form their organization, they absolutely can. Yes, they can, and two people can form a DBA and they can register at their county and they can be a RADAR.

MS. HUFF: Any of our organizations can be RADARs, too?

MS. DAVIS: Any of your organizations can be a RADAR. You absolutely can.

MS. HUFF: It doesn't sound legal.

MS. DAVIS: In addition to this, I wanted to also talk about what we call our SPAS System, and this is the State Prevention Advancement Support System.

As I spoke about earlier, oftentimes it's very difficult to show what you have done, show your outcome, if in fact you've prevented something from happening, but one of the things that truly the very, very dedicated staff at CSAP have done is they've created what's called SPAS, and it is a technical assistance resource for states, but included in that is an actual web-based technology that allows states to actually capture prevention information that can actually then be sent up to CSAP, so that we get a very good picture across the country -- for people who have our State Incentive Grants and people as they utilize their block grant funds -- on the

actual outcome of what it is that they are doing. As we begin to look at the core measures, states use this web-based tool and they report on it and that information then gets to us and we are able to make the case for prevention across the country.

I want to share with you all again the National Dissemination System. Much of this is staying but some of this is changing as we speak and as we become truly a one SAMHSA, but I wanted to just make sure that you all know that as we look at dissemination, part of prevention -- and I think Dr. Pepper has talked about it -- it has a lot to do with information, and we have many, many, many ways to be able to get information out and I want to just make sure that you all as you look at this, that here are just some of the things and you all will have this slide presentation.

I do want to talk about NREP, the National Registry for Effective Programs. NREP was actually begun in 1996. I had actually the honor and pleasure actually to be with this group as this was started. This was started as a part of the National Center for the Advancement of Prevention, and in one of the actual board meetings, people talked about the fact that people talked about, well, how big is the prevention field? People want to know that. We actually realized that there was not really a way for us to really talk

about how many actual prevention programs are out there because prevention in many cases are woven into many things.

The registry was established to actually be able to take a look at effectiveness. Although many, many programs have been submitted to actually be declared effective as a prevention model in preventing substance abuse, to date, we have 54 programs that have actually been declared model, 43 of them have actually been declared effective, and 51 promising, and let me share with you the difference between them.

The program that I ran was declared a promising program. What that means is that there are things that you are doing that actually have promising results that have shown effectiveness. Effective programs mean that as people have implemented these programs, they have actually implemented effective strategies and in fact they have actually showed a reduction in substance abuse.

The model programs and the only difference between the model program and the effective programs is the fact that as a model program, you must agree and you have actually passed the same standard as an effective program, but in addition to that, you must agree that you will be willing to actually go out and train other people on how to actually implement your program.

To support that, CSAP actually has a large

contract. It's a model program dissemination contract, in which we actually will work with people who actually have model programs to help them disseminate their programs to other people. The reason why this is so important and I can speak from this as a former community person, oftentimes whenever you had to prove a program was model, the standards of that had to do with whether or not you could actually show through a control group setting that whatever you did was effective versus a group that did not have the intervention, so therefore their statistics did not change.

In communities, and many of you all know this, control groups do not go well, particularly in minority communities. People do not like to put their kids and/or interventions in control groups because you'll have one group of people get an intervention and others not, and when you're working with children, you run the risk of having two children in the same family, even though they have different last names, and so oftentimes, particularly in the prevention community, they fought back against this because control groups were just not accepted.

One of the good things about the model programs is the fact that this has already happened. The testing has been done. The control groups have been done. The interventions have been proven. So now, all that we have to

do is just export what we already know is effective and when you implement an effective program, you do not have to do a control group. You're now looking at the issues of adaptation. How do I adapt this to my community and how do I take this to scale? How do I take this marvelous program and get it to more than 25 kids? How do we get it to a school, and how do we get it to a school district, and how do we get it to an entire county?

This has really helped advance our field because people are taking these programs and they're adapting them and we are seeing promising results. Because the registry has been so successful, it has been expanded to actually include HIV, workplace violence, as you see, post-traumatic stress disorder, problem gambling, co-occurring disorders, and tobacco use.

I just want to let you all know this, and as I said again, you will have this slide, but the NREP process is truly an extensive and in-depth process, but this is actually a peer-review process where you have people and scientists and researchers in this field who are actually taking a look at all the processes and steps that actually make a program effective.

Our key with NREP, and I always say this, is that the challenge that we have is that we must get more people

into the registry for the billions of dollars that we have spent on prevention, the billions. As Dr. Gallant always reminds me, the billions of dollars that have been spent on prevention, it makes no sense for us to only have a hundred and something programs, which means as we look at what we are doing, that CSAP will in fact outreach more because in fact we know the innovations are out there. We know the good programs are out there. What we have to do is get them into the registry and in so doing, we'll be utilizing our CAPTs to actually hold science-to-service summits where many of the innovations have actually occurred. We have a lot of very effective programs but we will be helping these programs write up the things they need to write up so that we get more people into the pipeline.

PrevTech, I will share with you. This is a new tool that is in development and what this tool will do is for many of the communities that are out there, when they look at grant programs, although the states actually have a way to go on the web and actually report their outcomes, for the longest time, the actual program grantees have not had this, and in order to be able to make sure we have uniform reporting so that we can begin to again show the power of prevention in communities, what we are going to be looking at is looking at a site that will actually have tools and instruments that will

help communities capture this, capture what they're doing in prevention, so that they can begin to report this.

The Robert Wood Johnson Foundation, Annie E. Casey Foundation, many of them have had very elaborate MIS systems for a long time. The field is out there again doing some of these things. So it's incumbent upon us to begin to put this tool into place so that we have the kinds of information being collected that is web-based technology that can be reported from communities, from grantees at the community levels up to CSAP. This has not been unveiled yet. So this is in process.

Our partnerships, again through the block grants. We talked about the block grants, 20 percent of the set-aside. All states have the block grants and what I was going to say is that within all the block grants, 20 percent is set aside for prevention. So again, even as states are receiving their block grants, 20 percent of those dollars are set aside. This part of the block grant set-aside will turn to the performance prevention, the PPGs that you all have heard about, the Performance Partnership Grants.

The good thing about this and something that CSAP is doing differently is that as we look at the three things that CSAP does that deals with states -- that is Synar compliance, State Incentive Grants, and the block grants -- we

will actually be combining those so that the states will actually have one project officer who will work with them on all three of those initiatives, so that you actually will have someone who is actually working with them to solve their problems, utilizing the three mechanisms that we have to fund states.

Workplace programs. You all have heard that CSAP is truly known for our Workplace Division. We have been blessed with the National Drug Testing Standard site and we actually do work with developing all the comprehensive drug-free workplace programs. I want you all, when you get a chance to go to the CSAP website, to take a look at what we're doing in workplace programs.

In 2004, we're going to be looking at grant programs to really deal with the population that many of you all have heard about and that's the 18-to-25-year-old age group. They are truly the hardest group to work with. I remember in working with this particular age group, that we were looking at a summer jobs program or young adult job program, and I remember 30 percent of these young people could not actually get jobs because they couldn't pass the drug test.

We really need to begin to look at this and I think this is kind of the age group because at 18 to 25,

people see them as young adults, and so there's not a lot of programs out there and there aren't really intervention programs for young people because they're too old. This is that category that's really been left out. So we're going to be looking at that because again this is going to be our youth and we've got to make sure that they're going to be able to get into the workplace.

We're also going to be working with Community Anti-Drug Coalitions of America to strengthen what they are doing with the business community, working with Chambers of Commerce and community coalitions.

Let me just share with you, as I talked about earlier, partnerships with the way that we will be going forth. It is not possible for us to be successful without that. The Coalition Institute is a $2 million award that was given to the Community Anti-Drug Coalitions of America to administer coalition-specific prevention policy development and training, and as within the field of prevention, coalitions represent two-thirds of what it is that happens in prevention and this is truly where people are coming together in communities to actually do comprehensive strategies.

The Coalition Institute does work with ONDCP and OJJDP and certainly CSAP and CSAT, the CAPTs, et cetera, and with the Coalition Institute, the whole idea of this is to

actually develop the science around understanding what is it that helps the coalition be effective because the coalitions have quite frankly been in the field of prevention, the most effective mechanism we have used in actually reducing substance abuse in our communities.

We have a minority AIDS initiative which has just been an ongoing, in my opinion, just joy and wonderful. This is one issue that, if in fact we're going to do this right, we really can make a tremendous difference. If we can prevent the spread of HIV in combination with substance abuse, we will truly make a big difference.

We have had many of the grants starting back since 1999. Many of them are now going to be ending in 2004. So we've had five years worth of funding. So we're going to be able to actually learn some things about that to actually be able to work with HIV prevention really very well. We have done a lot of other things that I think are very important and one of those is helping communities have planning grants.

The issue of HIV has been around for a long time, but the issue of HIV in combination with substance abuse has not. Those two things have not really been looked at together. So what we are doing is helping communities through planning grants actually put the infrastructure in place. As we talked about earlier, it's important for communities to

know what their capacity is before they step out and decide to again address any particular issue.

What the planning grants give communities an opportunity to do is to actually step back, figure out what capacities they have, where in fact their need really is, what does it look like, what's the nature and scope of what it is they're trying to address and then begin to really come up with a good plan of action that will actually help them get true outcomes.

As we talked about youth tobacco prevention, CSAP does actually work with Synar compliance. We're responsible for tobacco prevention and actual compliance with the Synar law, which does in fact make sure that tobacco prevention is on the radar screen of states. There are compliance rates. I am pleased to say that we have 49 of the 50 states that are actually in compliance with Synar and actually, with this, what we are measuring is retailer violation to make sure that retailers are not in fact selling tobacco to minors.

In closing, let me just finish up with the rest of our remaining partnership initiatives. With fetal alcohol syndrome, we have actually established a Center for Excellence and this center was established to identify, support, and promote effective preventions with fetal alcohol syndrome.

I am pleased to say that in the past, CSAP has not actually been involved with Recovery Month and this year, CSAP actually became involved with Recovery Month not just in participating in the national kickoff with it but also in helping to sponsor a women and recovery conference. It actually started yesterday. It is continuing through today.

This conference was truly to address women who both are pregnant and are also parenting fetal alcohol syndrome children, and it was just really interesting to be able to take a look at the women's faces yesterday in speaking with them because after I finished speaking, one of the women came up to me and she said, "You know, you've not only helped to validate the things that I've always believed, but you helped me realize that we really do affect the next generations. This disease is 100 percent preventable. Fetal alcohol syndrome and spectrum disorders is 100 percent preventable and this is something that prevention really needs to be at the table with, and I'm so glad that you're involved in that for recovery."

As she spoke to me, I really thought about the kinds of things that we were doing. The wonderful thing about having a Center for Excellence is if you look across the country, there are truly target communities. Many of them are Native American communities but then across the country, we

have actual areas where the fetal alcohol syndrome rates are very, very high, but oftentimes even if we put out a grant announcement, many of those communities would not necessarily be the ones who actually got grants.

So we're going to begin to look at the Center for Excellence as actually being able to help target dollars and TA and support to where they are needed, and this goes back to really being able to help build capacity because oftentimes some of the communities who really need the services the most are also not going to be the ones who may or may not write the best grants, and oftentimes we will miss the mark because those very communities will not be the ones who can get them.

By working with the Center for Excellence, we can begin to really target our efforts and really get services to where they are needed and to the people who need them. So I'm very, very excited about this. NIAAA will be working with us on this because NIAAA, in meeting with us, they actually have researchers they've given grants to to actually research fetal alcohol spectrum disorders and these researchers can't find communities in which to work. So I've said, oh, no, come visit me. Let us rethink this and so truly let us help you, and actually, in visiting with NIAAA, we will be partnering with them because as we have communities that are out there going to be doing this work, they will actually be providing

the researchers who can actually help study it, so we can really get best practices and really match research to practice.

Lastly and this will be the last thing that I talk about and that is going to be our Faith Summit. The communities of faith truly have a home with prevention. Many of the faith providers who are out there wanting to be involved in substance abuse fit very nicely with us because quite frankly many of them actually focus in as faith as a protective factor and faith is a protective factor.

This year, in working throughout SAMHSA, we are working with both the Community Anti-Drug Coalitions of America and the Department of Justice to actually combine our initiatives in the faith initiatives to bring many of the faith groups in to Washington to actually participate in a faith summit, but interestingly enough, the Faith Summit will be connected to the CADCA conference, the Community Anti-Drug Coalitions of America conference, and the reasons for that is that you will have the faith community being exposed to the largest convocation of prevention providers and people who are involved in prevention, but also to be exposed to over 120-something workshops that we couldn't possibly achieve on our own if we were just funding this by ourselves.

So by combining all of our dollars within SAMHSA

and then combining with the private sector, what we're able to do is move from being able to host 70 people coming for a faith summit to actually expand that to over 300 people who we will be able to scholarship to actually come to this conference and be a part of this conference. So we are really excited about the communities of faith joining with us in January to actually then to really connect with the prevention field and connect up with the many people who are in their neighborhoods, their networks, their states and their communities, that they can partner with who actually go after SAMHSA dollars or go after Labor dollars or HHS dollars or anything else that's out there, but they can connect with these people so that we can begin to really support that prevention infrastructure and that continuum.

And lastly, I think in just closing, I just simply really wanted to be able to say that as CSAP moves forward, we truly are a part of one SAMHSA. Everything that we look at doing, it is about partnerships with our other sister and brother centers, but also, too, to figure out as we look at how we help to change business. Mr. Curie talked about being able to change business around the whole issue of substance abuse and that's what we will be about.

As I said earlier, no one ever addresses this issue by itself and no one ever comes to us with just a drug

problem. They come to us with having the disease of addiction coupled with family issues coupled with children issues coupled with homeless issues, jobs and all those other kinds of things that will prevent them from having that quality life in the community that everyone deserves, and so I'm real proud to be a part of this team. I think SAMHSA's going to rock. I think we will do a phenomenal job and it will make a phenomenal difference.

Every day that I wake up, I'm excited about coming to work because I know that everything we do, everything that we do is going to make a difference to somebody who is in the community. It's going to help a center be able to take someone else in. It's going to help someone improve their services. We're going to get something to one more person or five more people or we're going to help change the way business is done so we no longer have to see waiting lines, and sooner or later, Dr. Pepper, hopefully we'll change managed care.

(Laughter.)

MS. DAVIS: We will be able to return to the days when you can go into your doctor and you can talk to him about all of the things that are wrong with you that you need help with and that when people walk out of that office, that that doctor is connected to prevention and treatment and

intervention services and we help people truly really achieve a wholeness and actually achieve recovery and health.

Thank you.

(Applause.)

MS. KADE: I think we have time to take a couple of questions and then a break and then be ready for the next presentation.

MS. DAVIS: Yes, Dr. Pepper? I just love your name.

DR. PEPPER: I love your presentation. I only have one problem with it.

MS. DAVIS: Okay, sir.

DR. PEPPER: It is so broad and wonderful that I wonder why it's constrained by the inadequate title of your center.

MS. DAVIS: The Center for Substance Abuse Prevention.

DR. PEPPER: The Center for Substance Abuse Prevention, because the Center for Substance Abuse Prevention is so narrow and what you've described is so broad and is so consistent with SAMHSA, one SAMHSA, that I want Charlie to tell me the answer to my question.

MR. CURIE: I don't even want to touch changing the name of any center.

(Laughter.)

MR. CURIE: Bottom line, I think one of the beauties of the matrix is that it promotes and I think you see a broadening of CSAP's activity and mission because of our matrix management. You see a broadening of CMHS because of the same thing as well as CSAT. I think there's an argument to be made and we all advocate against the silos because we feel they cut down on opportunity for connectedness, flexibility. They get in the way of people engaging services, and in the matrix and making those walls permeable are critical.

On the other hand, the reality is when it comes to an identity of the field to federal programs and dollars and resources, CSAP represents a very important aspect of what occurs out in our communities with the coalitions we talk about and there's a very strong identity and history there and there is with all of them. So I think you can call a rose by any name, but I do think it's important for there to be that balance of being able to keep count of resources going into particular areas but make sure that how we operate that we're relevant to meeting the needs of people.

So if we were proposing to change the names of any centers, it would be the next three to five years of our efforts trying to just quell the angst about it and we

wouldn't get anything done. So it's a pragmatic answer, Bert.

MS. DAVIS: Yes, Dr. Gallant?

DR. GALLANT: No, no.

MS. DAVIS: Yes, Barbara?

MS. HUFF: I had a call the other day from Jane Adams, who runs our state family organization in Kansas and was on the President's Commission, and she asked me to ask you this and so I'm interested in it as well, and I thought maybe other people might be, too. So I thought rather than ask you in the restroom, I'd ask you this in front of everybody.

In your National Registry of Effective Programs, do you have consumers and family members that help judge whether or not a program can be on that national registry with those 18 criteria? Do you ever have families and consumers on the review panels or whatever you call that?

MS. DAVIS: I am so glad you asked that question and actually, Barbara, right now, the panels right now mostly consist of researchers.

MS. HUFF: Researchers?

MS. DAVIS: Yes, and many of them have worked for NIDA. They're very into university researchers and they've not been practitioners. Most of them have never been practitioners.

However, I will tell you that the NREP, as we go

into its next life cycle, will not only have consumers but family members because when you look at coalition and environmental prevention strategies, as we take programs to scale, you have to have people who actually have some program experience because the issues that come up in terms of fidelity, adaptation, et cetera, if you have never had to implement a program, there's no way you can understand what a provider has to go through to take a program from here to there.

That's the encompassing thing, as well as when we look in the environmental changes -- I mean, we can begin to talk about helping a classroom of 25 young people of smoking, working on strategies, et cetera, protective factors, programs, et cetera, but in fact, when a community begins to take all the vending machines out of a public place and pass a law that prohibits it from happening, you're able to take that to scale and those are some of the strategies that have been very effective around the country that have not necessarily been implemented. So we will have people who come from a broader array because when you look at the field of substance abuse, the experience level and the expertise is much broader than that just within the laboratory or in the research room.

So the answer is not yet but will be.

MS. HUFF: Call me. I'll get you some names.

MR. CURIE: Lewis looks like he's got a question.

DR. GALLANT: No, it's a comment. I must say it's nice to see that Charlie's decision of identifying a few good things and trying to capitalize on those are permeating the centers. I think for so long, they tried to do a lot of things, some they did well and some they did not do so well, but to put your energy behind a few good things, a few big rocks, as they say, and leave the little rocks alone, they'll take care of themselves at some point, I think is an excellent approach and I look forward to working with you, Beverly, and the other center directors to move your program along.

MS. KADE: Any other questions?

(No response.)

MS. KADE: Then I think it's time to take, I would say, a 15-minute break. So if you could return at 4:05, and then we will be presented with the Household Study results.

Thank you.

(Recess.)

MS. KADE: Joe, why don't we start, and then we'll gain momentum.

MR. CURIE: I might want to mention, Joe Gfroerer is the father of the Household Survey, and you might want to fill people in on how long you've been with this process.

It's been many years. He knows it inside out and I think the world of Joe and what he has done in the past and this year's been no exception in terms of the quality of his work.

Joe?

MR. GFROERER: Thanks, Charlie.

I started working on this project in the early '80s, so it's a little over 20 years that I started analyzing the data and became project officer in 1988. So I've been running the project for about 15 years now, but it hasn't been the same project over that whole time period. So it certainly has not been boring. In fact, it's a new project as of 2002.

First of all, I do want to mention that I saw Jane Maxwell this morning and she told me to give her best wishes to the Council and that she's sorry that she couldn't be here. She had to attend another meeting I was with her at.

I'm going to present the results from the 2002 National Survey on Drug Use and Health. Most of what's in this presentation is in the report that is out on the desk. I guess you probably all have a copy of the big report and that's filled with about 50 charts and figures and many of those you'll see in the slide show, but there's some other things in here as well that are not in the report. They were some other analyses that we've done with the tables. There's hundreds and hundreds of tables that we've run from the survey

that are available on the website that you can look at that are not in the publication.

A little description of the design of the survey. It's representative nationally and also within each state and the District of Columbia, the minimum sample size in every state, covers the civilian non-institutional population aged 12 and older. It's an anonymous face-to-face interview using computer-assisted interviewing. All the interviewers have laptop computers that they take to the addresses and interview the selected respondents and most of the questions and all the sensitive data on substance use and mental health are administered by the respondent themselves by keying in the responses on the computer. The questions come up on the screen and also in headphones that they can listen to the questions on. We had 68,000 respondents in 2002, about the same sample size that we've had since 1999 when we started with the state survey.

Some of the improvements we made in the survey in 2002 turned out to change the levels of reporting that we get in the survey. The two most important changes are, first of all, the name of the survey was changed to the National Survey on Drug Use and Health. It used to be the National Household Survey on Drug Abuse. We took household out of the name and we put health in and we took abuse out. We felt that would be

more favorable to respondents and also more clearly represents what the survey actually covers.

But the other thing we did was we started paying respondents an incentive payment for participating in the survey, mainly to increase response rates, to get more participation, and it certainly did that but it also apparently changed the reporting levels, and so what we have here is the 2002 data which are not comparable in terms of trends to prior surveys. We have a new baseline here. So most of what I'll present here is 2002 data compared with comparisons across population groups.

Let me start with tobacco use and here are estimates that 30 percent of the population 12 and older are using some tobacco product currently and that's with any use within the past 30 days. Most of that is cigarette use at 26 percent which represents 61 million current smokers.

This looks at cigarette use by age and gender, where we see that the 18-to-25-year-old age group has the highest rates of current cigarette use, about 40 percent, and among adults, males have higher rates of smoking, but in the 12-to-17-year-old age group, where the rate is about 13 percent overall, girls have a higher rate of smoking, 13.6 compared to 12.3.

Now, when we look at past month smokers by how

many days they smoked, the frequency of smoking in the past month, you see a different pattern by age group, that the younger smokers are more likely to be smoking infrequently. Only a third of the youth smokers are daily smokers but among the 26 and older, it's two-thirds of the smokers.

Now, alcohol use. We have three basic measures for alcohol use and this is all within the past 30 days. Any use would be just at least one drink within the past 30 days, and that's about half the population or 120 million people. Binge use would be at least one occasion in the past 30 days with five drinks on that one occasion and the prevalence is 23 percent, 54 million people. Heavy use would be five different days in the past 30 days with a binge, so five days with five or more drinks on each of those days and that's 7 percent of the population or 16 million.

By looking at the age distribution, this chart breaks out the past month alcohol users by the level of use, any use, binge use and heavy use. You see the heavy use is the red bar at the bottom which peaks in the 21-to-25 age group and you can see there are declines after that age group. The rates generally go down with age. Over on the left is the underage drinkers, the four bars on the left, 12 up to 20, and looking at that a little more closely, you can see here by single year of age how the rates progress from age 12 up to

20. Overall in this age group, 12-to-20, 29 percent of these persons are drinking alcohol in the past month, 19 percent with binge use and 6 percent with heavy use.

Looking at underaged drinking here, this is any drinking in the past month by race/ethnicity, and we see blacks and Asians with lower rates than other groups. Now looking at older adults, 21 and older, legal drinking age, and here we're looking at heavy use, again we see blacks and Asians with lower rates and we see, like we do with many of the measures that we have in the survey, the American Indian/Alaska Native population tends to stand out in a lot of these measures. They have the highest rate of heavy alcohol use at about 10 percent.

Now some of the data on illicit drug use. Here is the pattern of use in the current illicit drug users. The estimate is 19.5 million current illicit drug users which is 8.3 percent of the population and most of that is marijuana use. More than half of those users are only using marijuana, 55 percent, and then another 20 percent are using marijuana plus some other drug and these other drugs include a whole variety of types of drugs which you can see here, marijuana, psychotherapeutics, cocaine, hallucinogens, inhalants, and also heroin, and I should mention that the psychotherapeutics there, what that is is that's prescription-type drugs used

non-medically and that includes tranquilizers, sedatives, stimulants, and pain relievers.

Pain relievers is the largest category there. Of that 2.6 percent, 1.9 percent of it is just the pain relievers. That's ages 12 and older and here's the age distribution for any illicit drug use, again showing the peak in the young adult. Here's 18-to-20 age group at 22 percent with the rates going down with increasing age after that, and here is the racial/ethnic distribution, Asians again showing up with the lowest rate.

This is for ages 12 and older. The highest rates are among the American Indian/Alaska Native and the group that report two or more races, and one thing I'll say about that group that reports two or more races, more than half of them were reporting American Indian/Alaska Native as one of the two races. About half was American Indian and white and they also tend to be younger than the other groups in comparison here. So that kind of explains why they show up with high rates along with the American Indian population.

Now county type. Here we're looking at classification of counties by whether they're in metropolitan areas, large or small, and then outside of the metropolitan areas basically the population density of those counties and so over on the right you see the truly rural areas, rural

counties, and that's where the rate of illicit drug use is lowest at 5.4 percent.

Looking at a couple of special populations. Here we're looking at women aged 15-to-44. The blue bar is pregnant women, the yellow bar is not pregnant women, currently pregnant, and you can see pregnant women are much less likely to be using substances but still 3.3 percent are using an illicit drug, 3.1 percent with binge alcohol and 17 percent smoking cigarettes among pregnant women, and I'd also add that this is an overall rate among all pregnant women. If you look at just pregnant women in the first trimester, the rates are much higher than this. So in terms of the proportion of pregnancies affected, these rates are much lower than the rate of pregnancies affected.

Now looking at employment status, we can see that this is among adults. The rate of illicit drug use is highest among the unemployed population at 17 percent. Full-time employed is 8.2 percent, but when you look at this in terms of the number of people, because most people are employed, most illicit drug users are employed. About three-quarters of all the illicit drug users are employed either full-time or part-time and that's 9.5 million full-time employed illicit drug users.

Now looking at youth, we can see that boys have a

slightly higher rate of illicit drug use than girls, 12.3 versus 10.9, and that's mainly because of marijuana which is the primary drug of use in this age group as well as the others, but you can see the psychotherapeutics actually are higher among females and again that would be mainly the pain relievers. Race/ethnicity among youth again shows the American Indian/Alaska Native even more pronounced at 20 percent and Asians again with the lowest rate.

Here we have cigarette use. Looking at illicit drug use by cigarette use. So the bar on the left is youths who smoke cigarettes. 48 percent of them are using illicit drugs. The youths who don't smoke cigarettes, only 6 percent using illicit drugs. Similarly for alcohol, the heavier the alcohol use, the more likely the youths are to be using illicit drugs. Heavy alcohol use in that population, two-thirds of those kids are also using illicit drugs.

We have some questions on the survey that ask marijuana users how and where they got their marijuana, the last marijuana that they used, and about a third or 32 percent say that the last marijuana that they used they had purchased and about 61 percent say they got it free or they shared, a friend had given it to them. The pie is broken into the sources of that marijuana. Most of the time it's from a friend but you can see that among those who bought, there's 19

percent who bought it from some other person which is generally somebody they didn't know or had just met, whereas the people who got it free have got 10 percent getting it from a relative, probably a sibling, and also where was the marijuana obtained? Those people who bought marijuana, 13.5 percent got it at school, either inside the building or on the school grounds. In both cases, the place that's most likely to be where the marijuana was purchased is at a home or apartment or dormitory and that's about half of the marijuana obtained free.

Now looking at some of the measures that are related to youth substance use, risk and protective factors, we call them, here we're looking at perceived risk which is one of the first things we always look at, attitudes. Youth who perceive that there is a great risk in using marijuana are much less likely to be using marijuana, 1.9 percent versus 11.3 of the others.

Some data that I'll just throw in here related to that. This is from a report that's coming out in a few weeks on the state level estimates. Here you can see the states in red are the ones that have a low perceived risk among youth and the next slide shows the marijuana use by state. You can see it's the same states that have the low perceived risk are the states with the high rates of use, and then the third

measure that we would have related to that would be initiation or first-time use, new users. It's also very similar, not exactly the same but similar pattern. A lot of the same states show up with high rates of new use. These are the states that have low overall perceived risk.

This is parental disapproval and this is by asking the youth if they think their parent would strongly disapprove of their use of marijuana and the kids who think that their parents would disapprove are much less likely to be using marijuana, only 5.9 percent versus the others who think their parents would not be as disapproving, 34 percent of them were using marijuana.

Here we have religious beliefs. We have a series of questions asking people how important religion is to them and whether religion influences their decisions and you can see the youths who say religion is important are less likely to be using illicit drugs, and then this shows the relationship between illicit drug use and other deviant behaviors, delinquent behaviors, fighting at school or work, wearing a handgun, selling drugs, and stealing. All of these things are strongly related to illicit drug use.

I do have some trend data and just explain how this is created from the 2002 survey. We have a new baseline, so we can't compare the 2002 results to the 2001 and prior,

but from the 2002 survey, we can use data that was reported on age at first use and construct these curves from just the 2002 sample. I should caution you that there is likely to be some underreporting here because we're asking people to remember 20 and 30 years ago, their age at first use. So in terms of the actual height of these lines, they may be a little low, but the point here is to look at the curve and when the changes occurred, when the peaks and valleys were, and you can see that, consistent with all the findings we've had in the past, for marijuana use we have the increases in the '70s, peaking around 1980, declines after that and then increases again in the '90s, and you see at the end of the 12-to-17 curve a decline. That is statistically significant a drop in lifetime marijuana use in that age group.

Cocaine looks like this with again the same shape curve but in a different place. You can see the peak is around the mid-1980s for cocaine use but also increases in the late '90s. Heroin shows an increase in the early '70s, peaking around 1977, then declines but again in the 1990s some more increases, including among 12-to-17-olds, and this is Ecstasy which has shown dramatic increases in the past four or five years in all the surveys, and this is non-medical pain reliever use which also is showing increases in recent years. Methamphetamine doesn't show the dramatic increases in the

recent years, but it really did show a big increase back in the early 1970s.

Now for cigarette use, what I've done here is just looking at 12-to-17-year-olds and breaking it out for males and females. You can see that up until about 1980, males had higher rates than females, but around 1980, they came together and the recent years, they're almost exactly the same, the last two years, but both males and females did show a decline in lifetime cigarette use between 2001 and 2002.

Now another way we can look at trends is initiation which comes from that same information that we get in the survey on age at first use, but here, instead of accumulating and estimating how many people have ever used the drug, we look at how many people used the drug for the first time in each of these years. So it gives you a little bit of a different picture. Actually the trends are very similar, but it does indicate in some of these cases that we may be seeing some declines in incidence at the end of the curve here in the recent years.

That's marijuana and here is Ecstasy again showing the increases. LSD did show a significant drop in incidence in the recent years and here are the psychotherapeutics, the pain relievers, tranquilizers, stimulants and sedatives. One thing to pay attention to here

is just the sheer number of people. In this case, psychotherapeutics, that's 2.5 million people each year using pain relievers non-medically for the first time. Similarly for marijuana, the estimates are around 3 million per year. So even though the data are showing possibly some turnarounds and declines in recent years, the numbers are still high when you have 2 or 3 million new users each year. That's trying for the first time. Some of them will continue but some of them won't.

Now here are the data on dependence, abuse, and treatment. This data comes from questions that we have on the survey that gets at DSM-IV dependence and abuse, diagnosis of substance use disorders, and overall, we have 22 million people with either alcohol or drug dependence or abuse in 2002, 9.4 percent of the population. The 18-to-25 group again has the highest rate at 22 percent and you also see here that overall, alcohol is the dominant drug, but in the 12-to-17 age group, it's really about half and half. The illicit drugs are much more dominant in the 12-to-17 age group whereas in the 26 and older, it's almost entirely alcohol.

This is what the rates of dependence and abuse look like by drug. Marijuana. Alcohol is not shown here but alcohol would be by far the highest prevalence, but here you have the illicit drugs. Marijuana, 4 million people with

abuse or dependence. The second two drugs are pain relievers and cocaine at about 1.5 million, and then after that you have tranquilizers, stimulants, sedatives, hallucinogens, heroin, inhalants, and sedatives.

Here we have treatment need and this is looking at illicit drug treatment need, people who have dependence or abuse in the past year or got treatment in the past year, 7.7 million with treatment need, and of those about 18 percent got treatment. The remaining people who didn't get treatment, only 4.7 of the total, 4.7 percent reported that they felt they needed treatment. We have questions where we asked people if they didn't get treatment, we asked them if they felt they needed it and most people say no, they didn't feel they need it. Now if they felt they needed treatment, if they report that they did need treatment, we also asked if they made an effort to get treatment and there, only 24 percent of that small slice of 4.7 percent said they made an effort. That's about 88,000 people who felt they needed treatment, made an effort and couldn't get it.

Now we also asked those people who didn't get treatment but felt they needed treatment why didn't they get treatment. A little over a third said they were not ready to stop using drugs. Another third or so said they couldn't afford treatment. Stigma issues and that's a variety of

categories that they reported that we've collapsed together here and called stigma, about 26 percent, and another 20 percent just said they didn't know where to get treatment, and then the people who did get treatment, we asked them how they paid for the treatment and we have about a third with out-of-pocket, 30 percent used private health insurance, and all the other sources there. I should mention that these are not the primary source of payment. There's multiple reporting here. They can report two or three of these different sources of payment. So there is double counting.

Then finally, just to show you the treatment need data, we also have that for alcohol. The number's much bigger here. We're talking about 18.6 million needing treatment for alcohol and here only 8 percent got treatment and similarly the ones who didn't get treatment, almost all of them say they didn't feel they needed treatment.

Okay. Last section here is the data on mental health problems and what we estimate with the survey is serious mental illness and the way this is defined is having any DSM disorder and also having impairment. So it's a more restricted group than what you'll hear many times in the news of how many people have different kinds of mental disorders. Here, you have to have the impairment along with it and our estimate is 8.3 percent of adults, that's 17.5 million adults,

and here is what the distribution looks like by age and gender, females having a higher rate at every age group and the rates generally decline with age. So the 18-to-25-year-olds again showing the highest rate of serious mental illness.

People with serious mental illness are more likely to be using substances, twice as likely to use an illicit drug, more likely to be smoking cigarettes, only slightly more likely to be using alcohol, binge alcohol use, and looking at it in terms of substance use disorders, not just use but dependence or abuse on alcohol or drugs, you see the circle on the left is basically the 22 million people with a substance use disorder and you can see the intersection there of 4 million who have a substance disorder as well as serious mental illness and this is among adults only.

Again with a different set of questions, we do ask people whether they felt they needed treatment and whether they got treatment. Among the serious mental illness population, almost half, 48 percent, did get some kind of treatment. Now that could include treatment at some mental health center or from a private physician or from a prescription drug treatment. So 12 percent were not treated and they also perceived that they had an unmet need. That's the red section there and looking at those people, we asked them why didn't they get treatment and here we have cost and

insurance issues dominating again with 50 percent and 28 percent reporting stigma as one of the reasons they didn't get treatment, another 25 percent didn't know where to go to get treatment, 10 percent said they didn't feel a need or that they could handle the problem without getting treatment, 9 percent reported a fear of being committed or a fear of taking medicine, and that's it.

I'll take any questions that you have.

MS. SULLIVAN: Out of the park. Congratulations.

MR. GFROERER: Thank you.

MS. SULLIVAN: Have to be thrilled. Great graphs, great everything, great research, great synopsis, great read. Just thrilled. Wonderful.

On the last one, as you said, multiple reporting. I would just like to know specifically when it came down to how many checkoffs, I would like to see really kind of the breakdown on reasons for not receiving treatment among adults with serious mental illness who did not receive treatment but perceived unmet need.

Do you have any kind of breakdown of that specifically? You allowed them to check off as many as they wanted.

MR. GFROERER: Yes. The question actually has, I don't know, seven or eight different categories and then

there's also a write-in and all those get coded and so there are many, many different reasons that people reported. The slide I showed is a collapsing into those major groups, but we do have the data broken out. I don't have it off the top of my head, but the detailed tables are available on the website that show each of the categories and how many reported each category, and it's actually broken out by whether they got treatment or not because what I showed was just the people who didn't get treatment but many of the people who did get treatment also report an unmet need at some time in the past year. Now that may be that they got delayed treatment or maybe the treatment they got was not sufficient, but nevertheless they're reporting an unmet need and we also have the data for those people.

MS. SULLIVAN: Thank you. It was just terrific. Thank you.

MR. GFROERER: Thank you.

DR. LEHMANN: For the serious mental illness group, how did you measure disability?

MR. GFROERER: Well, we started with the definition. This was the definition that was put out by SAMHSA I guess about 10 years ago along with the block grant formula, but we started with that definition and we actually did a field study with a whole series of questions and we

asked the questions and did the full survey basically, but then did a clinical interview with the psychiatrist after the survey and matched that up and came up with a set of questions that were the best predictors of serious mental illness.

Turns out there's only six questions that are needed to make that designation. It's called the K6. I don't know if you're familiar with these scales, but just six questions and we score it on a scale from 0 to 24 and count them if they reach, I think it is, 13 is the cut-off or something like that,

DR. LEHMANN: Okay, because when you said DSM-IV, I was wondering if you used the Global Assessment of Function Scale or something else. In fact, you used something else.

MR. GFROERER: The DSM-IV with impairment is the definition, but we did have some of the GAF questions in the survey. It was part of that whole assessment. They didn't end up being the predictors that were in the estimation, though.

DR. PEPPER: I've seen several recent studies indicating that caffeine use predicts higher cigarette use and therefore everything else that you pointed out with tobacco here. In the future, will you be including caffeine use in the Household Survey?

My second question is both a compliment and a

challenge. You're doing more about alcohol than in the past but you're not doing enough.

MR. GFROERER: There are no questions on caffeine in this year's or next year's survey, but it's certainly something to consider to look at, yes.

DR. PEPPER: I just want everybody to be aware that there are pretty good studies indicating that caffeine does initiate the chain of events that you so beautifully illustrated with your graphs. So I think it's worth considering, particularly since the drink of the day is caffeinated soft drinks. We're not just talking about coffee and tea anymore but the standard drink at school, for example, is caffeinated drinks.

COL. MESSELHEISER: I had just one question regarding perceived risk. Did that consist of a urinalysis testing, parents concern, law enforcement or what with regards to marijuana?

MR. GFROERER: The perceived risk is just a single question. We just asked do you perceive a great risk or slight risk in using marijuana. That could be interpreted different ways by different respondents. Some may think there's a risk because I might get caught, others might think there's a risk because it might hurt their health, but we don't get into that. It's just a simple question and it's up

to the respondent to interpret it.

DR. MESSELHEISER: Thanks.

MR. CURIE: One of the things I might mention that I find significant the last two years, we've had the mental health component, and one of the challenges we've had is quantifying, for example, the co-occurring issue. I know, Lewis, we've had many discussions about this, as well as Bert. It's significant that I think for the first time, we're now beginning to quantify an objective basis the fact that in this survey for this year, 4 million had a serious mental illness and co-occurring disorders. It can help us begin filling in that quadrant that we've had difficulty filling in in the past and so I'm pleased the Household Survey I think is bringing that outcome about and it's going to be invaluable, I think, in future planning.

MS. SULLIVAN: (Inaudible.)

MR. CURIE: The Household Survey.

DR. PEPPER: People should be aware that although the Household Survey identifies 4 million co-occurring with serious mental illness, that the number of co-occurring is more like 10+ million. Therefore, in the other three quadrants, we've got to distribute the other 6 or 7 million and I don't know that we have any data on that yet and I'm sure that Charlie's trying to figure out how to get it.

MS. DIETER: Can you tell me what these quadrants are that you're referring to?

MR. CURIE: Well, the Johari one. Jim and Lewis could do this.

MR. STONE: Imagine a window.

MS. DIETER: Yes.

MR. STONE: Imagine a window with four panes. I better write it out or else I'll get it mixed up.

MS. DIETER: Not my windows.

MR. STONE: The cross bar at the top is mental illness. The horizontal line is mental illness and the vertical line is substance abuse.

MS. DIETER: Okay.

MR. STONE: So the upper left, a person would be at high risk for mental illness and substance abuse, high right high risk for alcohol and low risk for mental illness, lower left the opposite of the upper right, and lower right would be low low. High high, high low, low high, low low.

MS. DIETER: Okay.

MR. CURIE: And the quadrant we were talking about just now would be the serious mental illness along with serious substance abuse which would be the highest. That's that 4 million figure we're looking at.

MS. DIETER: Right, but is there a way to -- how

often do you do this survey? Every year?

MR. CURIE: Annually.

MS. DIETER: Annually. To present that question of a less serious -- and I don't know how you quantify that. Emotional illness, emotional disturbance, whatever you'd call it, because it appears more and more that these are coming hand-in-hand and if they're identified at an early stage before they get to perhaps be a more serious mental illness, maybe they don't become one. Maybe they stay the same, and it would be interesting to see, particularly for the under 18 or under 25 age group, if there was some way to elaborate on that co-occurrence in a lesser -- you could help.

MR. STONE: The fascinating part about watching the trend lines is that in the early teens, the alcohol and substance abuse goes right off the chart with the same group probably because young people are starting to medicate their mental illness without realizing what's up.

MS. DIETER: That's my experience. I'm wondering if there's any way to try to look at that in this.

MR. CURIE: I know Drake has a lot of data on that and has done some breakthrough. Again, Joe can explain this process better than myself. Any time we begin to look at what questions to put in the Household Survey to capture a particular level of functioning or particular type of

situation, it would have to go through a process of testing and review.

MS. DIETER: Yes.

MR. CURIE: You might be able to share, Joe, what type of time table that would be.

MR. GFROERER: Well, the time table in general to test and review questions isn't so much the issue with the mental health data as it is coming up with the right questions ever at all.

MS. DIETER: Right.

MR. GFROERER: I mean, it's just so difficult. We've been working on this for years and years and finally came up with this serious mental illness measure, but really it takes too much time is the problem. We need to do it with a short scale, but we can't put 45 minutes of questions on this drug abuse survey.

MR. CURIE: I suppose we could consider such things at least this type of discussion would have to have. Does the person know they have a mental health diagnosis of any kind, any sort of mental health issue, but yet they aren't functionally impaired according to the SMI could be another category that's developed.

MS. DIETER: Right.

MR. CURIE: So it'd be a matter of determining

what categories you're developing.

MS. DIETER: Right.

MR. CURIE: Lewis?

DR. GALLANT: One of the things I would recommend that we at least consider would be engaging the National Academy to take this on as a study and kind of let them figure it out, and it would be taken out of the hands of the two disciplines and put into hopefully an unbiased body who would look at all available data, analyze that data, come up with numbers that hopefully we could find believable and at that point move from there because I think as you're seeing, it's difficult to get the field to agree on what's what. I have a number, Bert has a number, the survey has a number, and --

MR. CURIE: You don't like the survey number?

DR. GALLANT: The survey number is not bad.

MS. DIETER: For instance, what is your question? Are there two questions to identify this co-occurrence or are there several? What are the actual questions? What is an example of the questions?

MR. GFROERER: Well, there's separate questions for substance use and for mental health. For the substance use, there's probably about 15 questions that get at the 7 dependence criteria in the DSM and then there are 4 abuse criteria. So we have to cover all those.

MS. DIETER: Okay.

MR. GFROERER: For every substance that they've used, alcohol, marijuana, and so that's much more complex.

MS. DIETER: Yes.

MR. GFROERER: Then the mental health questions are separate and that, like I said before, is really based on just 6 questions from the scale called the K6 which we have shown in a field test correlates very well with true serious mental illness based on a clinical diagnosis.

MS. DIETER: What are those questions, for example?

MR. GFROERER: I don't know what they are exactly.

MS. DIETER: Oh, okay.

MR. GFROERER: They're in the appendix of the report.

MR. CURIE: Yes. I was going to say the questions, I think, are in the appendix of the report.

MR. GFROERER: Yes, they are.

MR. CURIE: And we could make sure copies are available.

MS. DIETER: I have them.

MR. CURIE: So you have them?

MS. DIETER: I received it. I didn't see the

appendix.

MR. CURIE: Okay. And one thought would be at some point perhaps even putting the appendix questions in the report on our website.

MR. GFROERER: The whole question is on the website.

MR. CURIE: Okay.

MS. DIETER: Yes. I was just thinking about that because that seems to be, especially in this prevention effort, that type of linkage because it seems that it's clearly there with young people. So somehow if you could have that data to show, it would be great.

MS. KADE: Are there any other questions?

(No response.)

MS. KADE: Thanks, Joe, for a great presentation.

MR. GFROERER: Thank you.

MS. KADE: At this point, before we start with our closing remarks, I wanted to ask whether or not there were any other people in the audience that would like to give comment to us at this point, public comment? Yes, sir?

MR. DANNENFELSER: My name is Marty Dannenfelser. I'm with the Administration for Children and Families, an OPDIV of HHS, and there were questions that came up about help with grants and that sort of thing.

One of the programs that's out there is a major component of the President's faith-based and community initiative is the Compassion Capital Fund which happens to be housed at ACF but it is to serve the entire government really and to serve the entire faith-based and community organizations, so to help them find out about grants throughout the government, but it is housed there, and so there is technical assistance and things like that that is provided to help people with grants. Compassion Capital Fund. You can find it by Google or Yahoo type search but also if you wanted to go to www.acf.hhs.gov/programs/ccf for Compassion Capital Fund. I'll do it one more time. www.acf.hhs.gov/programs/ccf for Compassion Capital Fund.

There are 21 intermediary organizations that got funded last year and perhaps another 10 or so that are going to get funded this year. So there'll be in the neighborhood of 30 of these organizations that are out there to help smaller groups, smaller organizations, and in certain cases, they provide subgrants. For instance, the Institute for Youth Development provided a bunch of subgrants, I believe the range was between $5 and $50,000, the grants. So those are things for direct type of assistance with helping the homeless and different types of social services and things like that. So that is another area to consider if people are looking for

help in doing that.

Now it is a new program. We're going to be evaluating it and we want to see how effective these intermediary organizations are in helping people and really getting this out to the grassroots, but that is something you might want to consider accessing.

Thank you.

MS. KADE: Thank you. Any other public comments?

(No response.)

MR. CURIE: Well, I want to thank everyone for being here today and hanging with you today. I think we covered a wide range of current activities and you see what SAMHSA is up to currently and appreciate everyone's participation. I'd like to turn it over to Pablo to make nay concluding remarks and feel free to adjourn us.

DR. HERNANDEZ: Thank you, Mr. Curie. Again, thank you and all the staff for SAMHSA for this wonderful busy loaded day that my brain has just totally sponged out.

(Laughter.)

DR. HERNANDEZ: But I think Toian deserves the credit for that. No, no, no. I'm just playing. We worked on this together and it was heavy. But anyhow, I just want to make a couple of comments. Tomorrow, we're going to have the Cancer Roundtables. I know that there was a lot of stuff,

questions that you had today. I hope that tonight you will be able to rehearse your questions and come with some resolutions that you would like to bring to the table tomorrow. I mean, to have an action plan, that would be one thing.

Other stuff is that you gave your input as to your ambassadorship that you would like to consider and the areas where you want it. There still is time for you to volunteer to the list. So we need for you to add your names to other areas or other ideas that you have in reference of your ambassadorship.

Last but not least, be thinking by tomorrow so we can save some time, look at your schedules, see what is your availability in the month of December, at least we need to have that, for the next meeting. Your availability in the month of December for the next meeting. Definitely we know that's a busy time.

DR. PEPPER: I'm busy at Christmas.

DR. HERNANDEZ: Very good. So if you can think of the first week and/or the second week of December, preferably the first week, so then we can think about dates, so that way we can look at our agenda and be able to come tomorrow prepared to say can we or can we not.

MS. SULLIVAN: Could someone like Toian check on -- pregnant pause here -- when the White House Christmas tree

will be lit?

MS. VAUGHN: Mark is saying the second Thursday in December.

MS. SULLIVAN: Thank you, Mark.

DR. HERNANDEZ: So the second Thursday in December mathematically will be the 11th and 12th? Is that the 11th? Yes. It is the 11th, I think.

MS. HUFF: The first Thursday is the 4th, and then the second Thursday is the 11th.

DR. HERNANDEZ: Hey, you know, there's a mathematical thing here. But with nothing else that anyone of the Council would like to bring to the table, the meeting is adjourned for today and we will convene tomorrow at 9:00 a.m.

(Whereupon, at 5:07 p.m., the meeting was recessed, to reconvene at 9:00 a.m. on Wednesday, September 10, 2003.)